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THE NATIONAL STRATEGY FOR TREATMENT AND PREVENTION: THE ROLE OF HEALTH AND HUMAN SERVICES

HEARING

BEFORE THE

SELECT COMMITTEE ON NARCOTICS ABUSE AND CONTROL HOUSE OF REPRESENTATIVES

ONE HUNDRED FIRST CONGRESS

SECOND SESSION

JUNE 20, 1990

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(101st Congress)

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THE NATIONAL STRATEGY FOR TREATMENT AND PREVENTION: THE ROLE OF HEALTH AND HUMAN SERVICES

WEDNESDAY, JUNE 20, 1990

HOUSE OF REPRESENTATIVES,
SELECT COMMITTEE ON NARCOTICS ABUSE AND CONTROL,
Washington, DC.

The committee met, pursuant to call, at 9:35 a.m., the Rayburn House Office Building, room B-318, Washington, DC, Hon. James H. Scheuer (acting chairman) presiding.

Members present: Representatives James H. Scheuer, Frank J. Guarini, Kweisi Mfume, Joseph E. Brennan, Nita M. Lowey, Lawrence Coughlin, Benjamin A. Gilman, Michael G. Oxley, Christopher Shays, Bill Paxon, and Wally Herger.

Staff present: Edward H. Jurith, staff director; William S. Smith, minority staff director; Jennifer Ann Brophy, professional staff; George R. Gilbert, staff counsel; Michael J. Kelley, staff counsel; Robyn Rosenblum, professional staff; Robert Weiner, press officer; and Melanie T. Young, minority professional staff.

Mr. SCHEUER. The Select Committee on Narcotics will come to order. We are delighted to welcome to our midst Under Secretary of Health and Human Services Constance Horner.

The Secretary is at a meeting of the Domestic Policy Council this morning, and unavoidably detained. The Chairman of this committee is with Nelson Mandela in New York City and unavoidably detained. So you and I will carry on in fine style, Mrs. Horner.

This is not the first time you have been with us, Mrs. Horner. As you know, we're frustrated at the lack of progress. It's a very complicated problem out there, the whole problem of drug addiction. It involves almost every aspect of our society. It certainly involved the whole field of education and the confidence that young people have that when they finish school, they're going to make an easy transition into the world of work. That breeds confidence. That breeds self-esteem. And it's the lack of confidence and lack of self-esteem and lack of imagine and general frustration with one's likelihood of succeeding and being independent and having a fruitful productive life, that all of that brings, that leads to addiction. Addiction is not a cause, it's an effect. It's an effect of failure and the sense of failure and the feeling of failure, the environment of failure.

So nobody is laying it on any one government agency. There's enough blame to go all around. Congress, undoubtedly, could have done a better job and should be doing a better job. I think the same

thing is true with the administration. It's up to all of us working together and reasoning together to see if we can't come to a more effective collective answer to the problem of drug addiction in our society.

We're frustrated, for example, that there isn't a single Federal treatment center for drug addiction in the entire country. There's little, if any, accountability over efforts of States and cities by those who run the treatment programs that are funded by States and cities. There doesn't seem to be a set of national standards by which treatment centers and treatment providers can be judged.

The treatment modality itself isn't all that encouraging. Apparently the rate of recidivism—those falling back into drug use and drug dependency after treatment—is as high as 80 percent, which is a discouraging fact for all of us.

Another thing that frustrates us is the lack of drug treatment slots in our country. Apparently, there's a need for another 10.6 million treatment slots according to the National Association of State, Alcohol and Drug Abuse Directors, because we don't have enough treatment slots because only one out of eight or nine addicts who need treatment and want treatment are in a treatment slot, the others are inundating our hospital emergency rooms. Hospital emergency rooms are truly a very valuable, high tech facility with high tech equipment. They should be centers for traumas, for accidents, for heart attacks and instead they're filled up with people who are the victims of drug abuse and the violence that stems from drug abuse. This is surely a misuse of our Nation's operating rooms and, somehow or other, our society has to deal with that.

Our health care system is in the state of virtual collapse due to underfunding and overuse. The AIDS problem, which is not directly in your bailiwick, although I suppose that drug abuse and sharing of needles is a major contributor to AIDS, but the soaring AIDS population in our central city hospitals as overwhelmed our health facilities and brought them to the point of both economic and institutional collapse.

The failure to provide adequate slots for drug abuse victims is, surely, seriously compounding that problem where overdose victims and drug shooting victims are being wheeled into hospital emergency rooms and nudging out the accident victims and the heart attack and other traditional medical emergency victims for whom those facilities were designed.

We must find a way of dealing with mothers who infect their children while they're still bearing them and deliver drugs to them through the placenta. If there is a more tragic phenomenon in American life than mothers who infect their kids with drugs and deliver the drugs through the placenta, I don't know about it. This is enough to bring tears to anybody's eyes. To go into a major city hospital, to go to Harlem Hospital and visit the wards where they're taking care of infants who are addicted when they entered life and destined surely to have a very, very short lifespan on earth due to the drug addiction that was imposed upon them by their mothers, is surely enough to break the human heart.

I think we need to broaden our reach. You're an administration representative, Mrs. Horner. I'm not laying this on your shoulders,

but I think we have to think about the role that illiteracy and unemployability and lack of hope, lack of concern in that greater society out there, the burden that all of these produce when they produce kids who are out of school, out of jobs and, most of all, out of hope.

There was an article in yesterday's Wall Street Journal, page 10, entitled "Work Skills Panel Urges Major Changes In School Education and Job Organization." I don't know if you read that.

Under Secretary HORNER. I did read it.

Mr. SCHEUER. I hope you were as impressed by it as I am. Most of the people who organized that report, and incidentally it was headed up by two Republican former Secretaries of Labor, two extraordinarily talented and able individuals, Ray Marshall and William Brock. They both testified before the Joint Economic Committee at hearings that I held 1 or 2 years ago. They're brilliant. They say, and this report says, that the United States is doing worse than any of the developed countries in terms of the way we perceive of our noncollege bound youth, which is 70 percent of the youth in this country.

In countries abroad if a kid falls out, if he falls back, if he drops out of school, he becomes the focus, the immediate focus of great attention. He is counseled, he is grabbed by society, so to speak. He is led by the hand into remedial education and skills training centers. He is provided with an expedited transition from the world of school to the world of work. He or she knows he's going to make it.

In this country when a kid drops out, his little blip is off the computer screen and society forgets about him. There's no second chance. There's no fail-safe device as there is in other developed countries—Europe, Australia, New Zealand, Japan, and Canada. Our performance in the way we treat our noncollege bound youth is a national disgrace.

Again, I am not laying this on you, Mrs. Horner. But you are the administration's representative here and since you're here, I've got to lash out in anger, frustration, disappointment, and, also hope that we can do better and that we will do better.

Well, I'd like now to yield to my minority colleague, a ranking minority member of this committee and a very productive and constructive and caring member of this committee, Congressman Larry Coughlin of Pennsylvania.

Mr. COUGHLIN. Thank you, Mr. Chairman.

Madam Under Secretary, we certainly thank you for being here.

The Department of Health and Human Services has been given two major missions in the war on drugs; to improve the treatment of drug abuse, and to prevent drug abuse especially among our young people and I think the Department has shown strong leadership in both of these areas. If we measure things by money, as is sometimes done in Washington, your success has been remarkable. In times of tight budgets, you have succeeded in convincing the President to request a 79-percent increase in the Federal drug treatment funding over 1989. For prevention, your success is even greater. If we enact your request for 1991, we'll see an increase in these programs of 100 percent since 1989.

But your efforts have gone beyond money. You've made a firm commitment to fund quality and effective programs in both of these areas.

In the area of drug treatment, you've initiated a host of demonstration programs, research projects and legislative initiatives designed to provide quality treatment programs. On your own initiative, you've created the Office of Treatment Improvement to improve the quality of the Nation's programs.

You've asked the Congress to pass legislation mandating statewide treatment plans designed to improve the performance of treatment programs without taking too much discretion away from the Nation's Governors. I regret that Congress could not pass that legislation.

In the area of prevention you've told the Nation about the value of community-based prevention. You've told us about turning the mind of the community against drug abuse as the best way to ensure the success of our drug education program.

Due to yours and past efforts, we have seen some success in drug prevention. As the recent high school senior survey indicates, students are turning away from drugs because they have become increasingly aware of the danger. I think that's a very, welcome sign, indeed.

We are proud to have you before our committee and look forward to your testimony.

Mr. SCHEUER. Thank you, Mr. Coughlin.

Now a very distinguished member of the committee from the State of New Jersey, Mr. Frank Guarini.

Mr. GUARINI. Thank you very much, Mr. Chairman. I will not be long. I understand that what we're about to talk about is very, very important concerning the need to get drug users off the streets, not only for the sake of rehabilitation for themselves, from a humanitarian viewpoint, but more relevant, for the protection of society.

One of the areas that I'm very much interested in is what we're doing about the prison system, because it seems to me that 1 percent of the entire Federal prison budget goes for treatment, less than 1 percent, about $6 million. When we consider that over 50 percent of the Federal prison inmates have had experience, a great deal of involvement with drugs, many of the crimes that we have are drug related and in the State prison system I think we figure something like 80 percent is drug related. There is very, very little that's being done today to treat these people, and with the great recidivism that we have, even after they're out of prison, within 3 years they're back in prison.

What we're doing is neglecting to take care of a very important source of the problem that is plaguing our country; that is these people who are the most dangerous and are the criminal minded of the drug users. We have a drug strategy—I would assume a national drug strategy—on how to address this particular problem. I have introduced a bill—also introduced on the Senate side by Moynihan-Chaffee—to treat this area, and we're interested in hearing what the health services that we have, our Federal health department, have as a strategy in addressing this problem.

I know there is very, very little money that was requested in the budget, and I'd like to know how we are going to get to the source

of the violent criminals that we have who will soon be walking our streets.

I want to welcome you here this morning and your team, and look forward to hearing your perspective.

Mr. SCHEUER. Well, all right, Madame Under Secretary. We're delighted to have you here. You've heard our opening statements. We look forward to hearing from you right now. Your full prepared remarks, of course, will be printed in their entirety in the record, so you can chat with us informally if you'd wish.

There's one question that I hope that you will address. We have heard about a 20-percent reduction in casual drug use in our schools, and that is most encouraging. National Institute for Drug Abuse [NIDA] in their recent national household survey of drug abuse found a 33⅓ percent, or roughly one-third reduction, in casual drug use. This equates to a reduction from 12 to 8 million cocaine users this past year. But, unfortunately, there has been a doubling of drug use by hard core users—the once a week or more cocaine users—from 5.3 percent to 10.5 percent, roughly a doubling. That is very disturbing. The daily or almost daily use has gone from 2 percent to 4 percent. Perhaps you would address that problem sometime during your testimony. With these words and the remarks that you've heard, we're delighted to welcome you and please proceed with your testimony.

[Opening statement of Acting Chairman Scheuer appears on p. 47.]

TESTIMONY OF CONSTANCE HORNER, UNDER SECRETARY OF HEALTH AND HUMAN SERVICES

Under Secretary HORNER. Thank you very much, Mr. Chairman. I appreciate the opportunity to testify before the committee on behalf of Secretary Sullivan. He thanks you for the invitation to testify. As you mentioned, he has——

Mr. SCHEUER. And Charlie Rangel.

Mr. COUGHLIN. In absentia.

Mr. SCHEUER. In absentia while he's welcoming Nelson Mandela. He's also welcoming you just as enthusiastically.

Under Secretary HORNER. Mr. Chairman, there will be some very significant, I think, and productive exchanges going on here this morning between members of the committee and the panel. I certainly hope so.

I would like to place prepared remarks in the record.

Mr. SCHEUER. No objection, so ordered.

Under Secretary HORNER. If I may very briefly digress before I begin, I did read the Wall Street Journal article you referred to with great care yesterday. I think it contains recommendations that warrant a close scrutiny. Obviously, we're going to deal with highly technical issues of budget and allocation of funds here today, but I think we are all acutely aware that there are very large societal issues affecting young people today that need very broad addressing in order to solve just this one awful problem that we're dealing with specifically.

Mr. SCHEUER. Let me put a footnote on those remarks. I'm very pleased to hear you recognize this. That is a major part of the prob-

lem. And I just want to suggest that, of course, we're all now under budget restrictions. We're operating under very acute parameters of cash available for these programs. But let me just say once, and I hope I won't say it again, that these expenditures are not expenditures. They're capital investments in our kids with an enormous cost/benefit payoff.

We've done repeated cost/benefit analyses of the Head Start Program, which is probably the best thing that this Congress and this administration has devised to help kids make it at school. Middle-class kids have been getting a head start experience for a century. I was a head start kid—I am a head start kid. I was a beneficiary of an enriched preschool program. In 1923 when I went into it, it was called prekindergarten or nursery school.

I'll warrant that most of the members of Congress are products of a Head Start Program, albeit under another name.

We have identified Head Start as a program that has a cost/benefit ratio calculated at 6 to 1—for every $1 spent by the Government there's at least $6 returned to society. That doesn't count some of the indirect costs avoided from education failure such as the criminal justice system, welfare, public housing, out of wedlock pregnancy, and the rest. So it's a very, very conservative estimate of the cost/benefit ratio of 6 to 1.

One wonders whether a society can afford not to make those kind of investments in their most priceless asset, the promise of our future, namely our kids. Developed countries abroad do make these investments. We don't make these investments. I think that there's an even higher priority than meeting budget restrictions, and that is providing for a productive and healthy society down the pike 10, 15, 20 years. That is the greatest budgetary challenge of all: a productive, competitive society. If we have that, we'll solve our budget problem. If we don't have that, we'll never solve our budget problem.

I apologize for interrupting.

Under Secretary HORNER. That's all right.

Mr. SCHEUER. Please proceed.

Under Secretary HORNER. I think that's why the President has asked for an extra $500 million for Head Start.

Mr. SCHEUER. Yes; that would bring the percentage of people that are excluded from Head Start from about 85 percent down to 80 percent or 79 percent. But we'd still, under the President's extra $500 million, be providing for only 1 out of 5 instead of 1 out of 6.

For your information, Congressman Dale Kildee and I are sponsoring a full funding bill for Head Start that would bring it to full funding by 1994. I hope you'll carry the message back to the President that that is an essential factor in the total scheme of our national drug prevention program. If we have kids who are making it at school, they're infinitely less likely to retreat into that dark world of drug addiction.

Go ahead.

Under Secretary HORNER. Let me first reiterate the Secretary's very strong commitment to the war on drugs. No decent person, especially a health professional like Secretary Sullivan, can stand by and watch the devastation that drug abuse brings. Drugs and alcohol are destroying individuals, families and whole communities.

Many of us are forced to deal with drugs at our jobs and in our neighborhoods and in the schools our children attend. Too much of our future is at risk from drugs and alcohol, and that is why the President has placed drug abuse very high on both his domestic and his international agenda. The Secretary is committed to this fight for the long term, as I am and as everyone at the Department of Health and Human Services is.

The National Institute on Drug Abuse conducts regular surveys of the general population to discover and understand what is actually happening with drug abuse in this country. These surveys, including the Household Survey, the High School Senior Survey and the Drug Abuse Warning Network, are reliable and valid.

Last August at the committee's hearing, the Secretary was able to report the generally positive results of the 1988 Household and High School Senior Surveys. They both showed a decrease in the number of experimental, occasional, and regular drug users.

Recently, the Secretary released the fourth quarter of 1989 results of the Drug Abuse Warning Network survey. This survey of 431 hospitals in 21 cities across the Nation reports drug related emergency room visits. This is data, Mr. Chairman, this committee and the Department have relied on to explain what is happening in the streets.

While we cannot suggest that this data from just one quarter constitutes a trend, the fourth quarter results showed a 22-percent reduction in the number of cocaine related admissions to emergency rooms. We will be looking closely at the first quarter of 1990 results to see if they are similar and to determine whether there is, indeed, a trend. But it is data that further indicates that we are moving in the right direction in our demand and supply side efforts but, by no means, are we even close to victory. There are still over 14 million Americans who used drugs in the month before the 1988 household survey or 7.3 percent of the population 12 or over. Of these 14 million Americans, 7.6 million had used drugs 50 or more times during the year preceding the survey.

Thus, while we can take some satisfaction from the results of the survey, we cannot pull back in any way from the effort we've been waging. Instead, we should take a renewed impetus from these results to continue our efforts.

Earlier this year the President released the National Drug Control Strategy 2, as a follow up and refinement to Strategy 1, released in September of 1989. These strategies developed by Doctor William Bennett, Director of the Office of National Drug Control Policy, in and of themselves represent a major improvement in the coordination of the Federal response to the Nation's drug problem. Communication between Doctor Bennett's office and our Department, Health and Human Services, continues to be very strong. Doctor Bennett and Secretary Sullivan meet on a regular basis and the Department was instrumental in the development of both strategies.

HHS has the primary responsibility for the demand reduction side of the National Drug Control Strategy. Our budget, then, reflects most of the demand side efforts of the administration.

In fiscal year 1989, the Department estimates that it spent $935 million on its antidrug abuse efforts including treatment, preven-

tion, and research. In fiscal year 1990, the estimate is $1.47 billion and we've requested $1.67 billion for fiscal year 1991. This represents a 79-percent increase in funding targeted for drug abuse over a 2-year period.

For treatment, we are requesting $924 million for fiscal year 1991 as compared with $560 million for fiscal year 1989, also a 79-percent increase, which shows the commitment of the Federal Government to providing treatment for addicts.

Of the fiscal year 1991 request, $436 million will be funds distributed to the States through the Alcohol, Drug Abuse and Mental Health Services block grant, to be used for drug abuse treatment and rehabilitation. The remaining portion includes treatment provided through demonstration programs and Medicaid and Medicare expenditures for drug treatment for those who are eligible.

I want to take a moment to mention an administration proposal which has received bipartisan support in both the House and the Senate. The requirement that States develop and implement a drug treatment plan as a condition of receipt of ADMS block grant funds. The administration requested legislation in conjunction with Strategy 1 to implement the plan as a way of holding States accountable for use and management of Federal funds. Unfortunately, the measure was never passed.

With the cooperation of the National Association of State Alcohol and Drug Abuse Directors we are requesting States to submit plans as part of their application for ADMS funds using existing authority.

Under this authority, however, we do not have the ability to require States to submit and implement the plans as a condition of receiving their block grant allotment. That's why we are seeking legislation. On behalf of the Secretary I would urge the members of this committee to support the measure.

This year we added three new treatment efforts to the list of programs. The target cities, the critical populations and the criminal justice programs initiated this year with appropriated funds and existing authorities will further the Federal involvement in helping States provide treatment services and in finding out how best to serve different populations.

Recognizing the need for increased prevention efforts, the administration is asking for fiscal year 1991 almost twice the funding level for fiscal year 1989. Our prevention efforts include the High Risk Youth Program which focuses on the multiple risk factors that lead to alcohol and drug use among youth and the pregnant and postpartum women and their infant grants. Pregnant and postpartum women are a very critical population for us to reach.

We hope to find through these grants a successful strategy for preventing drug abuse among this critical population and for treating pregnant and postpartum women who have used drugs.

A new program in prevention, the community partnership grant, will help local communities develop coalitions of organizations to try to implement comprehensive prevention programs.

If the President's budget request is accepted by Congress, there will have been a 56-percent increase in funding for research into drug related areas over the past 2 years. While these funds are used for various research efforts to learn more about drugs and

drug abuse and to be able to develop prevention and treatment approaches and strategies, I want to highlight our medication development effort.

ADAMHA's National Institute on Drug Abuse through its work at the Addiction Research Center and through research grants and contracts has been mounting a different, yet complimentary, drug effort. While our attention has been drawn to discussion of treatment facilities and slots, National Institute on Drug Abuse supported research has been working with some success to find medications for the treatment of drug addiction. It does so with the full appreciation that such medications are not a cure and not a magic bullet for drug addiction, but a part of a comprehensive treatment program that includes counseling, vocational rehabilitation and other social services.

Pharmacotherapeutic interventions that reduce the craving for or block the effects of various drugs are being actively pursued by government and now private sector scientists and will serve as an important tool in fighting the war on drugs.

Congress, in general, and you in particular, Mr. Chairman, have been very outspoken about the effectiveness of treatment and prevention activities. The Department, as well, has been very interested in the question and continues to do research in both treatment and prevention effectiveness. Recently, we submitted a report to the Senate Labor, HHS, and Education Appropriation Subcommittee on treatment effectiveness, which I would like to submit for the record at this time.

Drug abuse is a chronic, often relapsing disorder. For the majority of those addicted to drugs such as heroin or cocaine a single episode of treatment will not yield a cure. Drug users may pass through repeated cycles of drug dependence, treatment, abstinence and relapse. But this presence of relapse and chronic disorder does not mean treatment won't work.

We need your help, Mr. Chairman, because for you and the Secretary the question is not whether treatment works, but how we can make it work more effectively. We need to know what types of treatment work best with what types of patients.

In dealing with this question, we are confronted with the ever changing face of drug abuse and the diversification of treatment approaches. In conjunction with the Department of Veterans' Affairs, the National Institute on Drug Abuse has developed the addiction severity index to provide a common severity profile which assesses seven areas commonly affected as a result of alcohol or drug abuse. This index enables us to characterize and then group clients so that we can begin to draw conclusions. This tool is being used right now by counselors to tailor treatment programs to the individual.

The various types of treatment can be separated into two groups: pharmacological and behavioral. The distinction is somewhat artificial since these kinds of treatment are quite often applied in conjunction with each other. While the pharmacological treatments will be evaluated in the laboratories, the behavioral approaches will have to be evaluated by reviewing information provided by treatment settings. With the diversity of clients and approaches it will take time to get a firm picture of what works.

The Department is committed to this effort. As we have done in the past, whenever we can draw conclusions on what works, we will make this information available to the States and to private treatment providers for their use in improving the effectiveness of their treatment efforts.

With respect to prevention, earlier this month the Secretary announced research findings from community-wide drug abuse prevention programs in Kansas City and Indianapolis which shows significant promise in reducing adolescent use of cigarettes and alcohol, marijuana, and crack cocaine. Program participants were only half as likely to use cocaine as those who did not participate. Early prevention works. It is the activity that will most ensure that the next generation will not face the problem we have today.

Mr. Chairman, my statement this morning is a very short, quick glimpse of what the Department of Health and Human Services is doing as part of this Administration's efforts.

I wish I could stay and answer any questions you and the committee members might have. Unfortunately, as I think you know, I have previous commitments that I must honor.

Doctor Frederick Goodwin, Administrator of Alcohol, Drug Abuse and Mental Health Administration; Doctor Charles Schuster, Director of the National Institute on Drug Abuse; Doctor Beny Primm, Director of the Office for Treatment Improvement; and, Doctor Elaine Johnson, Director of the Office for Substance Abuse Prevention are available to answer any questions you might have.

Again, I want to thank you very much for this opportunity to testify before you.

[Statement of Louis W. Sullivan, M.D., Secretary HHS, presented by Under Secretary Horner appears on p. 53.]

Mr. SCHEUER. Ms. Horner, we very much appreciate your testimony and understand that at the last moment you're pinch hitting for Doctor Sullivan. I'd just like to, before you leave, ask you one question.

You said "you hoped to find a strategy" for our youth and for our high risk substance abuse users. The word that "you hoped to find a strategy" is very troublesome to me and before you leave I just wondered what you mean when you say "you hoped to." Do we not have a national strategy for high drug users in our health department amongst our youth? The term is that you "expect to find one," when we've been searching for the last 10 years screaming for national policy is a very disconcerting term. I just wondered if you would clarify that before you leave?

Under Secretary HORNER. Yes; I think I can. Obviously, there's a close interaction between information and goals established. The more information we get, the closer we can get to a clear vision of exactly what works.

Now, our goal is clear. We have to respond to the needs of this population. I would like to ask Doctor Goodwin to give you a fuller answer on that.

Mr. GUARINI. As you leave here, you're saying that even though we recognize the fact that AIDS is getting out of control, high drug risk users are becoming worse and our nations problem is becoming exacerbated, we're still establishing data, we're still trying to establish goals, we're still searching for a strategy. If that's so, I

think that this committee that's been 12 or more years in existence, and that's about how long I've been on this committee, has failed to make its point with the Department of Health. I understand that Doctor Sullivan has just come into the position, but my fault would be with the entire health strategy of our country if we're still trying to establish goals and still trying to gather data.

Under Secretary HORNER. We have a strategy that is, obviously, interactive with the environment that is rapidly changing. It's not a static situation. We have a strategy, we have clearly set goals and I think you will hear quite a bit about what they are, including those directly for——

Mr. GUARINI. All right. Thank you. That's not what I understood you to say.

Under Secretary HORNER. We intend—we have a strategy.

Mr. GUARINI. Well, there's a difference between intending and having and there's where I'm faulting what you're saying.

Under Secretary HORNER. Having. We have a strategy. We intend to refine it as we garner new information from social and biomedical research. The word "hope" may have been an inappropriate one here, and a more forceful word more appropriate. We do have such a strategy and we do——

Mr. GUARINI. All right. I think you'll agree that the people of our Nation are really looking forward to leadership and that means that we know where we're going. And what our goals are. I can understand refinements of the strategy, and I accept your clarification. I thank you very much.

Under Secretary HORNER. Thank you.

Mr. GUARINI. I won't hold you any further.

Under Secretary HORNER. Thank you.

Mr. GUARINI. I'd like to acknowledge that we have had a few of the members of the Select Committee of Narcotics Abuse and Control join our panel. Mr. Mfume from Maryland, Mr. Herger from California, Mr. Paxon from New York, and Mr. Gilman from New York was recently here and will be joining us again soon.

May I ask Mr. Larry Coughlin, who is the ranking member of the Select Committee, to begin any questions that he may have.

Mr. COUGHLIN. Thank you, Mr. Chairman. I suspect I will not get my five minutes before we will have to leave to go to vote.

Mr. GUARINI. You can reclaim your time.

Mr. COUGHLIN. I hope you'll allow me to reclaim my time later.

I would like to ask a two-part question. One is, there's been a great deal of talk about treatment on demand and yet when this committee went to New York City to review treatment programs there, one of the things, we found was that, yes, some treatment facilities have waiting lines but other treatment facilities had open slots. Although the quality of the treatment varied all over the lot, there was treatment available. In my own city of Philadelphia, I found the same kind of problem. I guess I want a comment on the question of treatment on demand because there's some impression that those who want treatment can't get it. Could you comment on that?

Dr. GOODWIN. Yes, Mr. Coughlin. I might start out by saying in response to the earlier comment by Mr. Guarini that there is always a time lapse, of course, between the impact of a program

and when it is initiated. Most of the efforts we're describing today are programs that have been initiated in the past 2 years—some, in fact, only in the past few months. Although it's frustrating to us, it is important that we make it clear that dealing with this epidemic requires vigorous action but it also requires careful action so that we don't end up 5 years from now saying that we moved too quickly in an area where we didn't have a solid base of knowledge.

In the issue of treatment on demand, you highlight the very important point of maldistribution or lack of coordination between various treatment centers. Doctor Primm who, of course, has run one of the pioneering drug treatment centers in the inner city in New York could comment on his experiences in New York about vacancies in some centers and waiting lists in others.

In fact, the primary responsibility or one of the primary responsibilities of his Office for Treatment Improvement is to see to it that there are central referral units in the major cities. We're in the process of selecting five to seven target cities to start these programs. These central referral units will ensure that we don't have waiting lists in one clinic and, down the block, another clinic with unused treatment slots.

There is considerable confusion about the question of the number of slots and the number of addicts. We may get back to this later. The ability to count addicts in this country when you're dealing with an illegal activity is problematic. There are data from our criminal justice system which, if extrapolated to the general population, would be considerably higher than from our National Household Survey.

We acknowledge that our Household and High School Survey data are underestimations because they do miss some of the highly vulnerable populations. But if one were to take a reasonable estimate of the number of users who are addicted, and apply to that a professional judgment about how many addicts would accept treatment if offered—and this, of course, is a critical variable—our best professional estimates are somewhere between 25 and 50 percent. That puts aside the question of whether they're willing to stay in treatment, because that's more complicated and Mr. Scheuer made reference to the discouraging dropout rate issue and recidivism and why we need to continue research on treatment so that people will stay in it long enough to benefit.

Mr. GUARINI. Doctor, I understand we have 2½ minutes to vote.

Dr. GOODWIN. Okay.

Mr. GUARINI. So we will adjourn and suspend for about 5 minutes. Thank you.

[Recess.]

Mr. SCHEUER. The committee will resume its activities. I'm going to yield now to Congressman Frank Guarini and then after that when Congressman Coughlin comes back, I'm going to yield to him and then I will have some questions.

But I do just want to express my disappointment that neither the Secretary nor the Under Secretary is here available for testifying to Congress and to answering the questions of the Congress. It seems to me that the purpose of these hearings are to hear the testimony of top-most officials in the executive branch and to have them respond to questioning. When the Secretary is called to a le-

gitimate Cabinet function it seems to me that it would only be proper courtesy for the Under Secretary if need be, to rearrange her schedule and arrange to be here to make a full presentation of the Department's views and to be here and available to answer Congressmen's questions. It's a matter of deep regret to me that this has not happened and that neither the Secretary nor the Under Secretary are available for our questioning.

This is not in derogation of the real talent and the fine experience of the four people at the witness table. But, still, I miss the testimony and the ability to respond of the Secretary or the Under Secretary.

Congressman Coughlin, why don't you proceed with your questions?

Mr. COUGHLIN. Thank you very much, Mr. Chairman.

We were discussing treatment on demand. I know that one of the things that has been said is that for someone who really wants treatment and is really seeking treatment, the facilities are probably there or at least with the funding that we have provided, will shortly be there, in most places. Is that in accordance with your vision of where we are?

Dr. GOODWIN. May I first just respond to Mr. Scheuer on Secretary Horner's behalf.

It was my understanding that her schedule was rearranged because of the 24 hour notice of her appearance, and it was very difficult to rearrange the whole morning. However, she did rearrange the part of the morning that was necessary to be here.

Now I can go on to respond to Mr. Coughlin.

The treatment on demand issue, as I was saying before the interruption, first should be addressed as how many drug addicts are likely to accept treatment. We estimate that is close to half the total population of addicts. We think that if you extrapolate those figures from our surveys of roughly 4 million addicts in the country, that we still have a shortfall; that is, there are still unmet demands. But that should be matched to the issue of distribution.

We also feel that simply providing slots without providing effective slots is shortsighted. Since we know that there is a big gap between the minimalist approach to drug abuse treatment and what is optimal, we not only need to apply what we already know, but we also need to learn more. There's considerable gain to be made in treatment improvements efforts, and that is why we have sought Doctor Primm's leadership.

Finally, I should make a point that there is a finite rate at which a treatment system can be expanded, and that's limited by the "siting" of treatment centers, the resistance of neighborhoods to have treatment centers in them, and the need to work with communities. It's limited by the rate at which we can train drug abuse counselors. We don't want to repeat the situation where you have counselors who apply for $11,000 a year jobs advertised as "no experience needed." Some of the problematic effects that develop from trying to expand too rapidly would, in fact, drive the quality of the system down, and our biggest problem is to maintain and enhance the quality while we're expanding the system.

I might see if Doctor Primm has any further comments on that.

Dr. PRIMM. Well, let me respond to the problem by saying that the treatment on demand, I think, is not what we should be talking of——

Mr. SCHEUER. Will you speak into the mike, please, Doctor Primm?

Dr. PRIMM. Surely.

When we talk about treatment on demand, I think we should phrase that a little bit differently. I think the demand for treatment is very vast; it depends on a number of different things: First, it depends upon the availability of the drugs out there, second, it depends on police policies, third, it depends upon the policies of the criminal justice system itself, screening, relapse rates, the availability and the effectiveness of treatment. All of those things have a tendency to control the demand for treatment.

I think your own GAO reports on methadone maintenance treatment programs for IV heroin users, for example, pretty much state that there was really no waiting list, that people could get into treatment if they applied to methadone maintenance treatment programs.

Just the other day, the Director of Daytop Village in New York reported that he had never had a waiting list in that theraputic community, a fact which even surprised me.

My concern is that what we need to do is a proper demand assessment for treatment, through establishing central referral units within cities so that we can have a handle on the need of treatment. What is the demand for treatment, what is available? As you know the kind of treatment that we have to offer is very variable because the whole drug abuse scene changes on a daily basis.

Today heroin might be the problem. Tomorrow it might be heroin and cocaine. The next day it might be crack. The next day it might be methamphetamine. So we talk about treatment on demand—we have to tailor the treatment to the needs of the individual, different strokes for different folks, and improve the quality of treatment. In doing that, we make treatment more efficacious.

Mr. COUGHLIN. One follow up question if I might. Since one of your responsibilities is research on treatment, could you comment on the development of an effective treatment modality for cocaine and crack addiction. We have a methadone treatment that we used for heroin, but we don't have anything like that for cocaine and crack addiction. Could you comment on the progress of research to find a treatment modality for that?

Dr. GOODWIN. Yes; I'd like to ask Doctor Schuster to give the details of that. I would just point out that the psychosocial complexity of cocaine addiction—that is the relationship between the biological changes in the brain and the environment—is more complex than it is in heroin addiction. Therefore, the search for medications that can reduce craving involves complex research designs that include both animal and clinical studies. That is one of NIDA's principle research emphases now. I might point out that the time line between the beginning of a research program of this sort and the clinical results is measured in several years or even decades. We're used to that in medicine in general, so we don't expect that when we do a massive investigation or research effort on AIDS, for example, that we'll have a cure for AIDS within a

couple of years, or a vaccine within a couple of years. I think the same is true for this complex, chronic, socially embedded biologically related drug addiction problem.

Doctor Schuster, could you expand on our medication development program?

Dr. SCHUSTER. You're absolutely right. At the present period of time we do not have well established treatment programs for the problem of cocaine and crack addiction. However, within the context——

Mr. SCHEUER. What does "well established" mean?

Dr. SCHUSTER. We have treatment programs in the United States that have reported success with certain kinds of interventions. Some of them are pharmacologial interventions. There are other studies which have looked at a drug called carbomazepine, which is an anticonvulsant drug, and there are many other studies. These need to be confirmed, however, by appropriate clinical studies. At this point these are observations by good clinicians, but as you know you must do placebo controlled studies to rule out expectancy factors and other factors of that sort which often times make things look good, when in fact they do not turn out to be as effective as we would like them to be.

So NIDA's in the process of studying a number of drugs which have been suggested by astute clinicians to be effective in treating cocaine addicts. But we are subjecting them to appropriate controlled studies.

In addition, I'd like to point out, we now know the neurochemical basis of cocaine's addictive properties in the brain, which we didn't know just 3 years ago. We also know the long term consequences of exposure to cocaine on neurochemistry. In animal studies these effects last for weeks and months after the cessation of cocaine administration. Knowing those two things will allow us to rationally develop new medications to, first of all, block the euphoric and addictive properties of cocaine in the same way we can block the effects of heroin. And second, to reverse the chemical disequilibrium which cocaine has produced, because we think this is what is responsible for the prolonged craving and relapse rates which we see amongst cocaine addicts. That information did not exist until, literally, the past year. Now we can proceed in our medications development program and have a rational development of medications that will interact with both of those neurochemical events.

Mr. COUGHLIN. Thank you, Mr. Chairman. I see my time has expired.

Mr. SCHEUER. All right. Congressman Frank Guarini of New Jersey.

Mr. GUARINI. Thank you, Mr. Chairman.

Is that the reason, Doctor Schuster, that we are not moving forward very fast in treating people that want the treatment, need treatment and want to get off the streets and off the drugs? I understand that currently, according to the National Association of State Alcohol and Drug Abuse Directors, there are 1.4 million drug and alcohol addicts in treatment and perhaps, 60 percent of those are alcoholic, the lesser amount drug addicts and all are in need of drug and alcohol treatment. There are 10.6 million addicts, which means only one in nine of those in need is actually being treated.

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Now, I know not everybody applies, but I understand there are long waiting lists and there are people who want to help themselves but receive no help whatsoever and cannot get medical assistance that they need. I'm just wondering whether or not you feel that the Federal Government is dragging its feet because the state of the art of treatment has not reached high enough levels?

Dr. SCHUSTER. First of all, I don't know where those figures came from.

Mr. GUARINI. The National Association of State Alcohol and Drug Abuse Directors.

Dr. SCHUSTER. Yes; I understand that. But I think that they're including alcohol as well and that inflates the figure.

Our Household Study showed that there were 4 million people 12 years of age and over who use an illegal drug 200 or more times in the past year. That figure seems to me to be a reasonable estimate of those who are in trouble. They need help.

Mr. GUARINI. According to statistics you're correct, because it's a 40/60 split, alcohol and drug abuse.

Dr. SCHUSTER. OK, fine.

Further, I think, as Doctor Goodwin pointed out, many of these individuals are unwilling at this point, at whatever stage they're in, in the addictive process, to come into treatment. On the other hand, I would say to you that we can combine outreach programs which do go out into the community using exaddicts and encourage people who are not originally interested in getting the treatment to come into treatment.

I think there's a couple of factors——

Mr. GUARINI. But isn't there a long waiting list out there?

Dr. SCHUSTER. Not——

Mr. GUARINI. As I understand, in some areas there's up to a 9 months waiting list, some of it's been dropping but there's still a long waiting list. Even in the District of Columbia there's a waiting list.

Dr. SCHUSTER. I think you will find that that varies tremendously and it depends upon whether or not the individual is willing to travel. By that I mean that there may not be a program in their neighborhood, which of course would be ideal. We don't want to have people spending exorbitant periods of time trying to get to and from treatment. The fact is, that there is treatment available in many places if they are willing to seek it out.

Mr. SCHEUER. Excuse me. What does "seeking it out mean?"

Dr. SCHUSTER. Well, I'll tell you exactly. At the present time, for example, here in Washington, DC, there is a central intake facility. People go to the central intake facility and the publicly funded treatment programs that are available here in the city are then matched to this individual.

Mr. GUARINI. Are you saying there's treatment by demand in Washington, DC?

Dr. SCHUSTER. I didn't say that there isn't a waiting list. But I am saying that individuals can come to that central facility and present themselves. They will be put on a waiting list if one exists at that time. However, there are also other private programs that they may be able to afford, that they can go to. In addition, there are self-help groups which are very effective with certain kinds of

people, at least as an interim device until they can get into a regular treatment program.

Mr. GILMAN. Will the gentleman yield?

Mr. GUARINI. Yes.

Mr. GILMAN. Well, what is the waiting list at the central placement facility? How long is the waiting list in Washington?

Dr. SCHUSTER. I wouldn't want to say, but that can be provided for the record.

Mr. GILMAN. Could you provide us with what the waiting list would be in New York City metropolitan area? Maybe Doctor Primm might know that. Do you know how long a waiting list is here, Doctor Primm?

Dr. PRIMM. We just had a GAO report on the waiting list in New York City particularly, and drug treatment programs treating intravenous drug abusers. You also have regulations that govern when a program gets to 90 percent of capacity, it must report that to the State and something must be done about it. If a person is on the waiting list longer than 7 days, that program must communicate with another program, find treatment for that individual.

The GAO found that programs, particularly in New York, were abiding by that rule and doing just that. The GAO report that you also requested on methadone maintenance treatment programs talks about the waiting lists on methadone maintenance treatment programs being solved, and that, indeed—and here's the report for you, Mr. Gilman—indeed, that people can get into treatment if they apply for treatment in methadone maintenance treatment programs.

Mr. GILMAN. How long is the waiting list now for regular treatment, not methadone, in the New York City area?

Dr. PRIMM. Well, I can't say exactly. I was just in a meeting—I had one of my emissaries in a meeting with Cardinal O'Connor's group in New York and Monsignor O'Brien of Daytop Village reported that they have never had a waiting list.

So waiting list information is fed to us through the press around the country. I think it's soft in many instances. I think also that what we need to do is get a handle on it by getting central intake units—just like Doctor Schuster was talking about that we have already established here in Washington, DC—getting a needs assessment, a demand for treatment assessment and have a handle so that we can begin to report on these things very accurately.

Mr. GILMAN. Thank you, Doctor.

Mr. GUARINI. If I can reclaim my time.

Mr. GILMAN. Just one request, Doctor Schuster, would you provide this committee with a list of the waiting times in some of the major cities at the present time?

Dr. SCHUSTER. If I may——

Mr. GILMAN. Mr. Chairman, I would like to ask that it be made a part of our record.

Mr. SCHEUER. Yes; waiting times not only for methadone, but for heroin and for cocaine.

The most thorough information we will have on waiting periods will be available in the spring of 1991. The data will be derived from ADAMHA's 1990 National Drug Abuse and Alcoholism Treatment Unit Survey, which collects information from all alcohol and drug abuse treatment programs and obtains client demographic profiles,

client counts, and treatment capacity by type of treatment. Although no question on waiting lists was included in last year's survey, respondents this year are asked: "Do you have a formalized waiting list? If yes, how many persons were on this list on September 28, 1990?"

In the meantime, ADAMHA will contact the 30 States that contain the 50 largest metropolitan areas and determine the current status of waiting lists in these cities. We will also contact all of the States that submitted applications to ADAMHA's Office for Treatment Improvement's Target City program and ask their permission to review the applications for relevant need data. Waiting list information may constitute one of the elements in establishing need.

Dr. SCHUSTER. Let me just point out——

Mr. SCHEUER. Methadone is the treatment of heroin.

Dr. SCHUSTER. Let me just point out——

Mr. SCHEUER. The waiting list for demand across the board.

Mr. GUARINI. Are you saying methadone is the only way to treat heroin?

Dr. PRIMM. Not at all, sir.

Mr. GUARINI. So, therefore, there are two issues then?

Dr. PRIMM. Right.

Dr. SCHUSTER. Let me just say, Mr. Gilman, that we can provide data that is currently existing, but the best data will be collected in September. This year for the first time as part of our national drug and alcoholism treatment unit survey, we are asking treatment programs to provide information on their waiting lists. The first national estimate on waiting lists will be available in the spring of 1991.

Mr. GILMAN. Thank you, Mr. Chairman.

Dr. GOODWIN. Let me say, too, that the one reason we've asked Congress for legislative authority on the State treatment plans is that we can require as a condition of Federal funding that this kind of data be provided. One of the things that happened back when the categorical programs—the Federal programs—for drug treatment were enrolled in the block grants in 1981, by congressional action, was that we lost the capacity to collect data from the States. We have just regained that capacity recently by corrective congressional action. It's taking a while to get the kind of information that we and you want very badly. Clearly, those State treatment plans will, indeed, give us the wherewithal to be more precise. But I want to point out as Mr. Guarini pointed out, that if you take the drug abuse, the drug addiction data from the NASADAD survey, it matches the NIDA data to the household survey. There are about 4 million that both the State directors and we estimate. So there's no argument about that data.

Of those 4 million——

Mr. SCHEUER. Four million what?

Dr. GOODWIN. Four million people who are addicted. Not abusive of drugs, but addicted to drugs. That's where we have to focus because the general use pattern is going down. We are seeing improvement in that end of the spectrum. We're seeing the problem shifting more and more to addiction away from just general use. That's why we're trying to home in on addiction as the problem.

Now, of that 4 million, we estimate generously that up to half would accept treatment. I don't mean they would have to be highly motivated. They would accept treatment if we first went out and offered it. That's what some of our outreach studies indicate, that

about half, that's about 2 million—it's estimated by NASADAD to be about 1.2 million spots now. So there still is a shortfall of treatment slots of somewhere around 800,000—somewhere between 1 million and 500,000. But it's important to say that, because when you mix alcoholism and drug abuse and drug addiction all together, it makes it sound like only one out of eight people is getting treatment. That's not the situation that we find.

Mr. GUARINI. Well, the question is, is part of the national strategy, that's what we're talking about in this hearing today, to have treatment on demand? That to reach the goal that we can treat everybody that needs treatment, get them off the street, get them the help they need and then follow up, which means training, rehabilitation and return to society? Do you have a program in place for that strategy?

Dr. GOODWIN. That is, in fact, the strategy and that is, in fact, the goal. But recognizing that delivery of treatment is primarily a State and local responsibility with Federal support being important partly as leverage for leadership. Of course Federal funds are important to funnel through the block grant.

Mr. GUARINI. Well, that's an important point. Is the primary responsibility State and local government in your scheme of things or is the primary responsibility the Federal Government to oversee that all of local and State efforts are coordinated?

Dr. GOODWIN. The primary responsibility for coordination, leadership, standardization lies in Federal/State partnership, and that's why we've asked for legislative authority on the treatment plan.

Mr. GUARINI. Well, now you're talking about partnership with so many tens of thousands of cities and partnership with the 50 States. Where is leadership, Doctor? Does the Federal Government assume the responsibility for getting rid of this scourge in America?

Dr. GOODWIN. The Federal Government assumes the responsibility for providing the national coordination and the leadership. However, the Federal Government should not, in our opinion, assume responsibility for the delivery of care at the local level.

Mr. GUARINI. So, therefore, the Federal responsibility for improving treatment effectiveness and accountability is not in the Federal Government, in your opinion and your strategy, is that correct?

Dr. GOODWIN. No; I didn't say that. I said that the actual delivery of care is primarily a State and local responsibility.

Mr. GUARINI. So, therefore, treatment is the local and State responsibility, and the Federal Government in areas such as Medicaid and other health delivery services is not the leadership role; it's a partnership role? Is that what you're——

Dr. GOODWIN. I wasn't speaking about direct transfer payments such as Medicaid and Medicare.

Mr. GUARINI. I'm talking about block grants. I'm talking about responsibility for winning this war on drugs. Where is it vested?

Dr. GOODWIN. It depends on——

Mr. GUARINI. It depends. See, we're not even clear as to where we're going. That's our problem.

Dr. GOODWIN. No; I don't think that's our problem. I think that I'm having trouble making it clear where we're going. Forgive me.

My point is, you cited treatment improvement. Treatment improvement is primarily a Federal responsibility, but that has to be cooperatively worked out with the States because the States de facto, do have the primary responsibility for the delivery here. We contribute about 20 to 22 percent through our block grant.

Treatment improvement, expanding the knowledge base, standardizing treatment and ensuring linkages of treatment systems is primarily a Federal responsibility. That's why we created the Office for Treatment Improvement.

Mr. GUARINI. Well, let's take State prisons. Eighty percent of the people who are State prisoners are drug abusers or drug users, people who need help that will return to society.

Dr. GOODWIN. Right.

Mr. GUARINI. Is the Federal Government taking any leadership role in seeing that those people who are incarcerated in State prisons, the worst of our drug abusers and our violent criminals, get treatment in the States? What is being done about it?

Dr. GOODWIN. We are very definitely, and I'll be happy to describe or have Doctor Primm particularly, describe the details of those programs.

One of the reasons we wanted authority from Congress on State treatment plans was to include the requirement that they link their State treatment programs to their State prison system. As you know, the prison systems are predominately State prison systems. You referred to the data which is very, very impressive data about the number of drug addicts that run through those systems.

Mr. GUARINI. It certainly is.

Dr. GOODWIN. We agree with that. That's why we need to be able to require the States to link their treatment systems to their prison systems as part of our block grant requirement.

Mr. GUARINI. Lastly, let me ask you, now as a person who could administer block grants, are you for the Chafee-Moynihan bill that I've introduced in the House that asks for additional sums of money for treatment in State and Federal prison systems?

Dr. GOODWIN. I'll have to look at the details of the bill and how it's structured, but we certainly feel that there is a gap in treatment in the prisons. Dr. Primm's Office for Treatment Improvement has linkages to the prison system as one of its top three priorities. There are many programs in the $137 million OTI budget that directly relate to prisons. I could not answer as to that particular bill. We don't have a position at this time.

Mr. GUARINI. So we have no strategy in our prison systems, and isn't it true that there's only $7 billion that's spent, demonstration grants, in our entire prison system and that that's just a piddling sum of money to address the problem that must be addressed?

Dr. GOODWIN. The major efforts in my agency in this area are in their first year. Those are the Office for Treatment Improvement programs, as Doctor Primm would be happy to describe if we have time. The past history of this has not been adequate, to be sure. I agree with you on that.

Mr. GUARINI. We haven't addressed a strategy yet either?

Dr. GOODWIN. No; we have a strategy. We have a strategy that ranges from requiring States to link their treatment systems to their prison systems, to categorical demonstration grant programs

administered by OTI to try to discover innovative approaches for getting and keeping prisoners in drug treatment, including the follow-up after they are discharged from prison. There's a whole array of other programs that Doctor Primm could either provide details for the record or, if we have time, comment on at this juncture.

Mr. GUARINI. Well, I won't take any further time, but I must say that there's much to be done in this area and we do have to get a permanent handle on a national policy and strategy, sir.

Dr. GOODWIN. We agree, there is much to be done. I would just reiterate my statement that there are, unfortunately, time lags that are a function of when the program was started. In the area you're questioning, these programs all were started within this fiscal year and, as a result, it's simply too early to be able to give you the results of the work.

Mr. GUARINI. Well, it's just unfortunate that we would address the problem so late when we've known we've had it for such a long period of time.

I won't take anymore time, Mr. Chairman. Thanks.

Mr. SCHEUER. Congressman Oxley?

Mr. OXLEY. Thank you, Mr. Chairman.

Doctor Primm, you and Doctor Sullivan headed up the American delegation to the United Nations Drug Conference in London a couple of months ago and some of us on the committee were honored to be able to participate in that very worthwhile program sponsored by Prime Minister Thatcher and Secretary General Perez De Cuellar of the United Nations. We also had an opportunity to visit one of the treatment programs, maintenance programs, really, in the inner city in London.

I was wondering what your impressions were comparing the British system to our effort, particularly to our strategy? It seemed to this Member that despite some good work over there, their emphasis appeared to be more on the maintenance aspect—more so than trying to prevent drug abuse or trying to get people from a maintenance program to a drug free demeanor. Both of us had an opportunity to witness this and question them. I thought, for the record, it would be interesting to hear your personal perspective as a doctor and one who has worked in this area comparing and contrasting our strategy to what goes on in England.

Dr. PRIMM. Thank you very much, Mr. Oxley. I'm happy that you posed that question. The philosophy that drives the treatment approach in Great Britain, of course, is one of harm minimization—do no harm—and that particular philosophy is not one that we have in this country. What does that mean? In many instances it means to explain to people how it's safe to use drugs if they don't come into treatment. There is no forcing. You visited a program and Mr. Gilman and I visited a program; there is no forcing or coercing or pushing people into drug treatment programs.

I see it as a coddling of a number of people who are substance abusers in that nation. A coddling that I don't think is a good strategy at all. I think when you look at the number of addicts in Great Britain and compare the number of addicts to this country, the culture is different, the composition of the addict population is different, and as a consequence of that, the approach is different.

There's an acceptance of addictive behavior or chemical dependent persons in that system. Acceptance that as long as they do no harm to society, society will do no harm to them. They don't have treatment programs in prisons. They also give out needles and syringes, as you well know, and in a program we visited they even tell people how to safely use those needles and syringes in order to take illicit drugs. I don't think it's a good program at all. I think it would be a disaster if we adopted that modality or that philosophy for our country. I feel that we are on the right track with a strategy that has been presented thus far. So that's my opinion about that program.

I was very disappointed in their program, but that's fine for Great Britain. It's not fine for the United States.

Mr. OXLEY. Well, I'm glad you pointed that out, because that was the same impression that I received. Of course, their argument was to us, as we questioned them, was that were they more aggressive in trying to get people off drugs, they would, in fact, drive people away, and users would not be encouraged to come in and get clean needles, for example, and would, therefore, use dirty needles. Viewing the British program was frustrating. On the other hand, it presents a stark contrast to the national drug strategy that we're talking about this morning. I think that to the extent we can perhaps use their example, albeit perhaps a bad example, to strengthen our resolve to work more toward getting people, not just using cleaner needles or just maintaining their addiction but, in fact, getting them that next step toward getting off drugs is useful.

Doctor Goodwin, I noticed you were nodding over there. I wonder if you have any comments in regard to what Doctor Primm and some members of the committee and Doctor Sullivan witnessed over in Great Britain and how that, perhaps, relates to the national drug strategy in this country?

Dr. GOODWIN. Well, we're concerned that anything done in the treatment system not send the wrong message to our prevention efforts. One of the things that's very important to the overall prevention efforts is to create a climate for young people of disapproval of drug use in general. Addiction is the final end product of drug use and is a tragedy, a health tragedy, a social tragedy.

The problem with the compassion with a large "C" approach, or exclusively compassion, is that it can send a conflicting message to young people that this is a behavior that society will take care of if a person slips into it. There has to be a balance between compassion on the addictive end, where a person really has lost a lot of their voluntary behavior, versus the entry end of the drug addiction problem where the person has substantial voluntary behavior. So the prevention programs that Doctor Johnson is heading up could be undermined if we had a national message that would be conveyed by distribution of clean needles and treatment and giving heroin to heroin addicts or legalizing drugs. You know, these are all variations that are built into legalization proposals. What's forgotten in all those legalization arguments is the implicit double message that it's sending to kids who are struggling with this decision of whether to start or not.

Mr. OXLEY. Just one last question, if I may. There have been several stories and television shows recently about chaos in the emer-

gency rooms in some of the larger public hospitals in the country in major cities. I'm wondering, if a strategy has been developed to help those folks out? It seems to me they are literally on the front lines of the drug plague in our major cities. They see it every hour. People come into the hospitals in all sorts of disarray, and I'm just wondering how the emergency room procedures and the problems that they have are being addressed by HHS? Doctor Primm, did you have a response?

Dr. PRIMM. I would be delighted to comment on that, because I see something far greater than what's just been reported in the press. When people in minority neighborhoods particularly in the Harlems and the Bedford-Stuyvesants, and the South Bronxes and the Washington, DC's of our Nation have to use the emergency room as their primary care provider or their primary care physician, it creates a "magnogocius" problem, if I may borrow a word that could describe it from "Mary Poppins."

It is unquestionably one of the worst situations that our Nation faces. Now what we intend to do, at ADAMHA primarily through our Office for Treatment Improvement is, hopefully, provide primary care within already existing drug treatment programs. Hopefully, drug treatment programs can act as the health maintenance organizations for indigent populations that happen to be chemically dependent and part of a drug treatment program. Not only does this make the drug treatment more attractive, and embraced by the individual, but we then can do something about the primary health of that individual and that individual's family. I hope to do that kind of expansion.

NIDA and OTI already have a relationship with community health centers that are set up for and run by the Public Health Service specifically for indigent populations. We have a joint effort with the Health Resources and Service Administration to create drug treatment programs within those centers and to beef up primary health care in drug treatment centers. This effort is going to be extended into next year.

I think something else is important here. When people go to the emergency room and have to wait hours and hours for treatment, they're sitting with other people who have tuberculosis, who have all kinds of different bacterial pnuemonias and other kinds of problems; these diseases are transmitted and are airborne, for example, and they have to sit there for hours waiting. The incidence of tuberculosis, the incidence of pneumonia in those areas where this occurs have risen precipitously. With HIV infection out there, lots of people have a diminished capacity relative to their immune systems, and tuberculosis is rampant. In Harlem alone, tuberculosis has increased 75 percent.

I think part of the problem is the contagion factor when people have to sit around in emergency rooms or in close quarters as they have to live. Even though we're seeing a reduction, for example, in the rate of drug dependence deaths in Harlem—also with cirrhosis of the liver in secondary alcoholism—we're seeing a rise in tuberculosis, a rise in pneumonia, and a rise in HIV diseases or opportunistic infections. I think it's important that you surface that issue, we're trying to do something about it, Mr. Oxley.

Mr. OXLEY. Thank you.

Mr. SCHEUER. Mr. Shays.

Mr. SHAYS. Thank you, Mr. Chairman.

No one can be blamed for the drug problem, obviously, no one individual, no one organization. We're all in this together. But I am struck by the fact that most of us were ready to be carried off to war last September when we waited with anticipation for our major strategy to deal with the drug problem. I get the sense that within the administration and even within the public that we're kind of sitting back. I don't sense any feeling of urgency on the part of the administration to deal with this problem.

I wanted to say one thing to you. Last year I had someone who treats young people come to me and say, "I'm treating five people in one school system and I had them all write out the first names of everyone they thought was experimenting not just with alcohol—that's a whole other issue and just as big—but substance abuse." He said, "We came up with 50 percent of the population in the senior class." These were in my suburban schools. So this year I've met with a group of students from each of my suburban schools—I'm not talking about the Bridgeport, Connecticuts that could rival the District of Columbia in some cases. I'm talking about the well-to-do communities in my district. These students were able to document for me, at least for my satisfaction, that we're looking at a problem where maybe 50 percent of our young people are, at least, not just drinkers and heavy drinkers, but are smoking grass, experimenting with cocaine. It just strikes me that in the 1940's 13 people worked for every 1 retiree and now we're at 3½ per workers per 1 retiree. The very generation that's going to school today, by the time they're 50 years old, they'll be two working for one retiree. The future of our Nation is really in jeopardy.

I've read the statement of Mr. Sullivan and I wanted to just ask you in general terms, "Are we spending all that we should spend for drug prevention and education? Are we spending all that we should spend?"

Dr. GOODWIN. Perhaps I could address that generically. The rate of spending has doubled within our agency for drug abuse in general in the last 2 years. That's a doubling. We heard references earlier, from Mr. Scheuer about the recognition of fiscal constraints, but certainly in the health arena, drug abuse spending has been the fastest growing component of the entire health arena, both treatment and prevention, and research. Our prevention efforts under Doctor Johnson's leadership have more than doubled—have tripled in the 2 year period of 1989 through 1991.

Mr. SCHEUER. I'd like to intervene just to ask a question and I will yield back the time, Congressman.

You know, you use this business it's doubled, it's tripled. Perhaps they have, but that only clarifies the abysmally, pitifully low level at which these expenditures are based. You know, 10 times zero still equals zero. When you have a national drug addiction problem that costs us, our society, well in excess of $100 billion a year, nobody knows how much; when you have an expenditure of several hundred million dollars and you double it to $500 million or you have $500 million and you double it to $950 million it's still at a trivial rate compared to the need. When you tell me that there are 10 million people out there, perhaps half of whom could well use a

drug treatment slot, you know, all of the applesauce in the world isn't going to hide the fact that we're not spending a fraction of what we ought to be spending to the kids who would take advantage of a drug treatment slot if it were there.

Now, I don't want to further invade the time from my colleague from Connecticut.

Dr. GOODWIN. I certainly agree in principle that in a generic sense this country drifted into a pattern of spending more on short-term issues than long-term investments——

Mr. SCHEUER. Would you say that we're pitifully under investing? Let's use the word invest rather than spend on our kids who are drug addicted.

Dr. GOODWIN. I personally feel that our overall spending in this country for children relative to other segments of the population, yes, it is——

Mr. SCHEUER. Relative to what countries abroad do who are no better circumstances than we are to face this problem, but who spend an infinity more than we do on our kids; on our kids' education, on the noncollege bound youth, as we discussed earlier.

Dr. GOODWIN. The problem, as you've identified, is that investing in children depends on a long-term view of improving things over decades rather than getting quick and immediate results. We're concerned in the drug war that we not get too involved in seeking too many quick results when we, indeed, have some long-term rebuilding efforts to do. Certainly we have to do more——

Mr. SCHEUER. It seems to me if you're looking for long-term benefits—we're talking about the Department of Health and Human Services—the first thing you might start with is full funding of Head Start.

Dr. GOODWIN. Well, that's what we——

Mr. SCHEUER. So you went from funding one kid out of six to one kid out of five. Big deal.

I yield to my colleague from Connecticut.

Mr. SHAYS. Thank you. I do want to concur with your statements, but I make this point: It really is a team effort and the administration recommends and we dispose to Congress' discredit, we have not fully funded Head Start. It would be helpful if the administration would recommend it. It would make the job easier. But I have that same sense about some of these other.

I am willing to vote for new taxes to fight a true war on drugs. I am embarrassed to even suggest that we are fighting a war. If I asked you: "Are we doing everything to stop the Nazi invasion?" You would say, "yes," and you would know that we had maximized it. You wouldn't say, "Well, we've spent 50 percent more on defense than we did last year." It just strikes me that it's a very telling comment you're making.

I don't want you to recommend that we spend more than we can adequately spend efficiently. But if we know education of young people, and older people as well, makes a difference, we're not fully funding education programs. We're not reaching every person. So, do you think we are spending all that we can to reach 100 percent of the market that's out there in education?

Dr. GOODWIN. I doubt that there's any part of the Federal budget that one could say, we're spending all that could be usefully spent.

All I was pointing out is that given all of the other priorities on the budget that it's worth noting that the drug abuse portion of that budget has grown at a rapid rate compared to other aspects of the budget. That has been the consensus both in Congress and within the administration. In my own agency it is the fastest growing portion of our budget by far, especially given the constraints on resources. Of course we are not competent in our agency to speak about issues relating to taxes, but given what we have to work with as a Federal budget, the drug abuse effort has been growing much faster. Certainly there are problems with where the baseline was, as Mr. Scheuer pointed out. But nevertheless, even with that there's a limit on how quickly you can expand the system. There's a distinction between the long term——

Mr. SHAYS. Sir, I understand that. Unfortunately, I was given a blue slip which says my 5 minutes has expired. But this is the point that I think this committee deserves an answer to. The question is not have we doubled or tripled. The question is: Are we spending all that we need to spend to maximize our effort? I think the answer is "no." I think it's the administration's responsibility to recommend we do that. We should fund up to the point where we're satisfied that we're funding treatment programs that work and not institutionalize bad treatment programs. But it seems to me the administration's obligation is to recommend that we go to the edge of that envelope. It's our responsibility then to see if we're willing to meet that challenge.

It seems to me that if you don't force us to do that, Congress with 435 House Members and 100 Senators is not going to meet that challenge. We're just not going to—we need that challenge from the administration. I don't think we're getting it.

Dr. GOODWIN. Well, the challenge for us is to design a careful step-wise progression to the solution of the problem. That's why we have been advocating a mixture of research, treatment improvement, and treatment expansion along with prevention. But the magnitude of that overall effort, I'm sure, will continue to be the subject of some debate.

I'd like to just make one more point in response to your personal experience in high schools. The high school senior data, which is very valid—with very careful questionnaires including asking the kids what they thought their classmates were doing—does indicate that there have been substantial and real sustained decreases over 5 years in mainstream drug use. We do not feel that applies as well to the inner cities. We do not feel that applies as well to the inner cities. We do not feel that applies as well, or to the same extent, to the dropouts. But if we'd look at the data we have and we scientifically obtain data, the broad-based prevention efforts that are underway in this country and the educational efforts, we would have to say that those trends are very substantial and they are encouraging. That doesn't mean that the war is won, by any means. It means that that part of the problem is going in the right direction.

The addiction end of the spectrum is less positive, particularly cocaine addiction where we don't know nearly enough about what works because this has hit us so recently, and because the nature of cocaine addiction is so complex. It involves cueing in the environment and you can get somebody off of cocaine as long as they're

in a residential treatment center, but we can't afford to put everyone in residential treatment centers for a year. We need to figure out what it is that can address that craving that defeats their ability to stay off drugs. That's part of our research effort and part of our treatment improvement effort.

I think you will find that if we look at the array of programs in this agency, that there's a whole lot going on because some of it is very new, all we can tell you is what we are in the process of doing. I wish we could tell you it's all done.

Mr. SHAYS. I'm not even asking that question. I know my time is up. But one of the problems with a 5 minute segment is that we simply can't pin you down to providing us the information we really need. It doesn't seem to me to be an unreasonable request for you to be able to say that within 3 years we hope to have full funding of all education programs, we think that's exactly how long it's going to take, or 4 years, and we're there. The students are telling me, yes, they're not experimenting with cocaine as much. They're using marijuana more and they're drinking a lot more.

Dr. GOODWIN. No; they are not drinking more. By our data their marijuana use is down and alcohol is down, not as dramatic as cocaine use but alcohol use is significantly down as is marijuana use. Particularly the more destructive forms of repeated binge drinking is down and daily marijuana use is down from 13 percent to 2.9 percent over 5 years. So these are data that are based on very statistically valid large samples of 16,000 schools——

Dr. SCHUSTER. 16,000 students.

Dr. GOODWIN [continuing]. 16,000 students in I don't know many hundreds of different schools across the country. This is a very valid sampling of kids who are in high schools. This does not represent dropouts. It does not represent homeless people and some of the more disadvantaged in society.

Mr. SCHEUER. All right. Thank you very much, Congressman.

Let me point out before going on to the other members, you're talking about the in-school population.

Dr. GOODWIN. Yes.

Mr. SCHEUER. Now when you look at the dropout population, which is about 30 percent of—in other words, 30 percent of the kids drop out across the country and in central core minority districts it goes up to 50 and 60 percent, upon this population drug abuse has doubled. I read you those statistics from NIDA. Okay? The daily or almost daily use group has doubled from 2 percent to 4 percent. The once a week or more group has gone from 5.3 to 10.5. Doubled. Okay?

So this only emphasizes how little we're doing to help the kids who have dropped out of school. Different from any developed country in the world. We ignore that. When they blip off the radar screen, we forget them, we turn our backs on them. We don't follow them up. We don't give them counseling. We don't give them a transition from the world of study to the world of work. We don't give them any help in improving their job skills and improving their education skills so that they can hold down a job in industry. We simply turn our back on them. To me this is a national disgrace.

If you're taking the long point of view, the best way to cut down on these out of school kids, out of work kids, out of hope kids is to give them a chance to make it in school. As I mentioned before, I'm a Head Start kid, but most of these kids don't get Head Start. They're the ones who need it the most.

It seems to me that the Department of Health and Human Services could have no greater mission than moving as swiftly as humanly possible toward full funding for Head Start. I think that was the point that Congressman Shays was trying to make.

Dr. GOODWIN. I'd like to point out, by the way, too, that in Doctor Johnson's Office for Substance Substance Abuse Prevention, there are now funded 97 programs around the country that total nearly $20 million, specifically focused on the school dropout population. The OSAP prevention programs, indeed, have community-school outreach.

Mr. SCHEUER. Excuse me, Doctor. When it comes to my turn to question, I'll discuss with you what an investment of $20 million means when you're talking about tens of millions of kids who aren't making it. It's pitiful. It is so grossly inadequate that it boggles the mind that you would even mention——

Dr. GOODWIN. I was giving you one segment. There's another $44 million in high-risk use, which include dropouts.

Mr. SCHEUER. All right.

Dr. GOODWIN. Overall, it's a substantial amount.

Mr. SCHEUER. Congressman Mfume?

Mr. MFUME. Thank you, Mr. Chairman.

I thank the panel for their appearance here this morning and to move to this area of treatment campuses, which I found rather fascinating in the summary of the report. Maybe I will just broach this to the panel and one of you can begin to respond to it.

The strategy that you refer to in your briefing papers, the paper that we have here, estimates that the total number of treatment slots funded by all sources in the United States on the high end will be approximately $700,000 and that you're able to serve on the high end approximately 1.7 million people as a result of that. I don't understand the math there, but maybe we can come back to that.

Dr. SCHUSTER. That's per year.

Mr. MFUME. Yes. I don't understand also, given the fact that I would hope treatment would have a different sense of priority than interdiction, why the President in his last budget requests put together a ratio that was essentially 70/30; 70 percent for interdiction and 30 percent for treatment. I thought that was kind of skewed in the opposite direction and would honestly hope that Health and Human Services would try its best to make the point to the President that many of us have tried to make over and over again about this need for treatment in the long-term approach to this problem. But what I find interesting in the strategy is that it calls for the development of large State and privately financed treatment campuses. I want to talk about that just a little so that perhaps you can share with myself and this committee just what is meant by that.

If you could begin to sort of address yourselves to the questions of what is the Federal role, or what do you anticipate the Federal

role to be in augmenting private support and providing resources for these campuses; to tell us whether or not you believe there are under-utilized military sites around the Nation that could, in fact, be suitable for such treatment campuses; when you expect to complete your review, which I understand is ever-evolving, when we could expect some results of that review and then why you believe that such treatment campuses will work? What makes you so gung-ho about this idea? If you are, does that translate to mean also, that the Secretary will try to impress upon the President, at least in the next funding package for the next proposal, that we turn the ratios around in such a way that we're able to do these sort of things?

I don't know how you put together a treatment campus without targeting resources and without making it a priority. I agree with the gentleman from Connecticut. I would like to see much more from the administration in that regard.

So, if you could address some of those questions, I would appreciate it very much.

Dr. GOODWIN. I'm going to ask Doctor Schuster and Doctor Primm to address the details of the campus proposals and the issue of the military bases, which we've been studying considerably. Doctor Schuster has responsibility for that study.

I'd just like first, though, to make a comment about the issue of interdiction and——

Mr. SCHEUER. Can I ask you all to make your remarks as brief as possible and to be responsive.

Dr. GOODWIN. Yes; I will. Just one comment on the interdiction effort. I think the 70/30 you were giving was interdiction versus all other—supply reduction versus all other activities.

Mr. MFUME. That's correct.

Dr. GOODWIN. The only body who does interdiction, of course, is the Federal Government. I think the more reasonable comparison is between law enforcement and State and Federal and local demand reduction, which is a mixture of State, Federal and local facilities. Those are comparable comparisons.

When you take interdiction out of it, which is a totally different issue, then you see there's roughly a 50/50 split between the law enforcement side and the treatment, prevention and research side.

Mr. MFUME. But the bottom line is that of the 100 percent, 30 percent, I think you'll agree with that, is approximately the figure that has been set up for treatment.

Dr. GOODWIN. I just felt it's a little bit of an apples and oranges comparison because interdiction is only done by federal government. There's no state activity.

Mr. MFUME. OK, let's stay with the apple—the 30 percent—which I don't understand, for treatment.

Dr. GOODWIN. But that does not include State money. That's only the Federal budget. The treatment system and the prevention effort include a very large amount of State money. So that's why I was saying those figures are a little misleading.

I'd like to ask Doctor Primm and Doctor Schuster to describe the treatment campuses and military bases.

Dr. SCHUSTER. Yes; I will be very brief about the military bases. We have provided the States with a list of the military sites that

are available. Unfortunately, it is my professional opinion that 99 percent of these are not going to be useful for treatment sites because they are underutilized, which means that during the summer when National Guard activities take place, they will be used for a period of 4 weeks. Well, you can't set up a treatment program on a campus and then vacate it for 4 weeks during the summer.

So, the vast majority of those sites are not going to be useful for our purposes. We are, however, looking into other alternatives with the Department of Defense for sites which may be better suited for this purpose. But for the present period of time, I don't think that it is a very realistic approach.

The treatment campus—I will simply say and then turn this over to Doctor Primm—is a notion that was based upon the fact that we have a great deal of difficulty in terms of locating sites for treatment facilities within large metropolitan areas. We thought that if we could find military facilities or old State hospitals that could be utilized for this purpose, that we could bring together a number of different private treatment providers. We would be funding that effort along with the States. The purpose is to look at these different treatment providers in terms of their efficacy.

The National Institute on Drug Abuse will be studying the effectiveness of different treatment approaches to the same population so that it will be providing service, but in addition it will also be looking at which of these approaches is maximally effective for what type of people.

Mr. MFUME. I understand it. I'm going to embrace the concept of treatment campuses. I support the Secretary and I think it's a proper approach to take. I just want to know how you envision it to develop and how you envision it getting under way in this country?

Dr. PRIMM. Well, Mr. Mfume, among the states and the federal government there will be cooperative agreements; that is, my office, the Office for Treatment Improvement, the National Institute of Drug Abuse and the States. Hopefully, in 1991, we will have enough money to fund at least two or three treatment campuses throughout the United States. Really, what it will also do is increase treatment capacity; hopefully, it will also increase quality of treatment. We'll have central referral units and a lower cost of treatment because, indeed, we will use probably the same medical facilities for whatever provider that will provide drug free treatment there. We will have different models of drug free treatment. We'll also have some substitution therapy that will be involved in the campuses seeing how efficacious that works in conjunction with other forms of treatment.

So, this will be, as you say, an excellent way to proceed—with cooperative agreements with the states.

Mr. MFUME. I understand my time has expired. I would appreciate, however, if you would communicate to my office a continuous review as to where you are in terms of site designations and whether it's possible to agree what you're looking at in fiscal 1991 and to at least be open and receptive with this committee for any suggestions that we may have.

I think it's a good idea. I just want to see it get started.

Dr. PRIMM. There's some very favorable sites in the State of Maryland, close to you——

Mr. MFUME. Flattery will get you everything.

Dr. PRIMM. Thank you.

Mr. SCHEUER. The Congresswoman from New York.

Mrs. LOWEY. Thank you. I particularly want to thank you all for being here today, in particular Doctor Primm, who is a constituent and has been a very helpful advisor to me.

I'd like to follow up on two of my colleagues questions, actually. First of all, I authored, with Charlie Rangel amendment which was tacked on to the defense authorization bill which would give high priority to turning over those closed military bases for use as drug treatment centers and prisons. What kind of coordination have you really had with Secretary Cheney?

With all due respect, Doctor Primm, I consider this a national emergency. I agree with my colleague Chris Shays' comments, because drug use in the schools is just as bad if not worse in Westchester County. It seems to me to be too modest to be talking about only two bases. You know, we talk about fighting a war against drugs. What a war. There may be a skirmish here and there, but I don't see a war. How can we talk about only two bases? We have a national emergency. Is there coordination with Secretary Cheney to really take advantage of these unneeded bases?

Dr. PRIMM. Okay. I think that Doctor Schuster is more——

Dr. SCHUSTER. Yes; we have a committee which has met on a regular basis to get information about the military facilities that are underutilized. We have provided a list of about 5,300 facilities to the States so that they can look at these and determine whether or not there are any within their State that might be useful for the establishment of treatment programs. That information has already gone out.

Mrs. LOWEY. Well, where's it going?

Dr. SCHUSTER. It goes to the States. The States have——

Mrs. LOWEY. Does it sit there for a year or two, or who is in charge of moving this forward?

Dr. SCHUSTER. Well, as Doctor Goodwin has pointed out, the delivery of treatment is a State responsibility. The legislation asked that the Director of the National Institute on Drug Abuse, with the Department of Defense provide the States with information about this. And that has been accomplished. As I said previously, we found that the vast majority of these sites would not be very useful for the establishment of treatment programs.

Mrs. LOWEY. Well, let me say this. I'm still looking at the possibility. I'm optimistic about the possibility of reusing more than one or two or three of these facilities, because I do think it's a national emergency. But I would also think that we could be creative and use National Guard centers such you mentioned.

For example, I've been in touch with the National Guard centers that may be closed up for their particular use. However, they are still open for facility use and personnel for a period of several months. Why couldn't we take some of these inner city kids out of their community for 6, 7, 8 weeks, keep them in outpatient treatment centers in their community and give them an intensive drug treatment experience?

You know, I think this is an emergency, and we have to think of those alternatives and not just say, "Well, you can't do it for 6 weeks. You have to do it for 1 year."

Dr. PRIMM. There is considerable competition, too, Mrs. Lowey, for those sites that you are talking about.

Mrs. LOWEY. Well, right now they're not being used for anything except keeping personnel fed and housed.

Dr. PRIMM. But you have to get in line. I think we are number three in terms of priority. Homeless is first, I think prisons are second, and drug abuse treatment and rehabilitation are third. So we have to get in line.

Not only that, there are many private investors who see these sites as a way to develop other very upscale living arrangements. For example, the Brooklyn Navy Yard is one where there is a considerable amount of friction between the Hasidic community and the African-American community; it would have been a lovely site to create not only training and treatment. We could even teach people skills to work on ships, et cetera, et cetera. Sea Train is there. They could learn other kinds of skills and still we have this problem. So, it's not as easy as one might picture.

The other thing is there must be a willingness on the part of the State to embrace this concept. That willingness has come to my knowledge from only one State, and that's New York. Now, of course, I hear Congressman Mfume saying that he would be in favor of it.

Mrs. LOWEY. Well, because my time is limited, I want to move forward. But let me say that I was very serious, as is Congressman Rangel, when we got this amendment passed. There are 86 bases, and I think we have to pursue this aggressively because there is a national emergency. I think we have to be creative with alternatives. If you can't use the base 12 months of the year, get these kids there for 6 months or 3 months.

Now, just to add to what my colleague Chris Shays said, I too have met with almost every high school and I've been to many of my elementary schools and many of our middle schools. In school districts where they have intense drug education programs, it is working. However, the kids have been turning to alcohol. So I'd really like to look at your statistics because I have talked to the kids and seen first-hand the facts about student drug abuse. Drug use is down in districts where they have intense education programs. Alcohol use is going up. But I was outraged at visiting some of my suburban high schools where drug education is a joke. Where an unacceptably huge percentage of those youngsters are still using coke, they're still using pot. They don't even see the seriousness of it.

Who is in charge? What is the chain of the command? Are we having a real war? I think it's serious and unless we begin with education, while we're trying to get kids and adults off drugs, we're not really fighting a battle.

Dr. PRIMM. Congressman Lowey, I think that you can consider me one of the generals that is in charge of this thing——

Mrs. LOWEY. Right.

Dr. PRIMM [continuing]. And particularly in Westchester County. You very well know that I believe in going into those schools on a

sustained effort, not just a rifle shot. I think you're absolutely correct. There is a war. I think the choice to bring me to Washington meant that there was going to be another General here in Washington that would do something about this problem. That's what we're trying to do.

It takes time to develop friends and people who have the kind of zeal and dedication that I have for this field. We're doing that. We're doing it around the country. We're encouraging young people to come in to learn in fellowship programs about drug abuse rehabilitation and prevention—professionals who are now in their third and fourth year of medical school. So I'm very happy that we're going to do something about the problem.

Mrs. LOWEY. Let me say, Doctor Primm, I'm delighted that you are a general, too, because I do have confidence in you and you're right on my home base. But I just wanted to alert Doctor Goodwin that my staff would be very interested in receiving these statistics because certainly in suburban Westchester County we see an increase. We don't really see in many of our school districts any impact at all. I think we have to deal with the facts, deal with what's out there and have a real all out attack. I don't think we can wait.

Dr. GOODWIN. As the man who recruited Beny Primm, let me say that we're very pleased that a man of his expertise and reputation is one of the people who will help us in this.

I might say that the high school data that we referred to is a national sample. There is considerable variability from one community to another, but the national sample does show modest downward trends even in the alcohol component of that.

I do think it's important to note that the kind of prevention programs that you described in the schools, some of our prevention research is now showing, are not adequate unless they're linked to other community efforts, particularly for the high risk youth. I do think they can be a joke, if you just go in and give a quick and varied drug abuse education course, and you don't identify which kids are troubled, which ones have depression, anxiety disorders, psychiatric problems, which ones are from broken homes, which ones are living in poverty. Unless you link it to community action—in fact, the STAR program, which is one of our more encouraging and hope-generating results of prevention, only worked when school and community prevention were linked together. That's why OSAP's prevention programs do not simply put money into the schools and leave it alone, but require that those programs be linked to community programs.

I said before the innovation of these programs, along with the creation by Congress of OSAP and the funding by Congress of OTI, are so recent that we can't show the impact that we will be able to show, I think, in a year or two.

Mrs. LOWEY. Let me just comment briefly, because I've gotten my blue slip, too. I'm aware of those studies, and I'm aware of the fact that OSAP has shown that you need to involve the whole community with child care and housing and you have to get the root causes that are turning these youngsters towards addictive practices.

I haven't seen, frankly, any progress in that regard. What are we doing now to get at the roots of drug abuses? I think that unless we are providing enough funds to expand antidrug education programs, we're all kidding each other.

I was very pleased to get additional funds into the Drug Free Schools and Communities Act as a member of the Education and Labor Committee. Student Assistant Services, as Doctor Primm knows, works. DARE has had some excellent success. But unless there's leadership and we make a national commitment, not to have a couple of skirmishes, but to take the knowledge we've gathered, implement it and replicate it throughout the country, I don't think we will succeed. It's serious, and we all know that.

Dr. GOODWIN. The community linked knowledge that you're referring to—and it's a pleasure to talk to somebody as knowledgeable as you are about the details—but the knowledge that you're referring to is, indeed, very recent knowledge.

Mrs. LOWEY. Right.

Dr. GOODWIN. Now Doctor Johnson is, in fact, implementing that in the grant announcements and the linkages that those grant announcements will require.

Mrs. LOWEY. Doctor Goodwin, one more comment and then I'll give this up. I'm not sure——

Mr. GUARINI. I just want to follow up on what he said.

Mrs. LOWEY. Okay.

Mr. GUARINI. I just want to know are we shuffling statistics from all these analyses that we're making? To follow up on what was said, is when we say a war on drugs a misnomer? Are we really fooling ourselves or just giving good literacy to it when we say the "war on drugs"? Is this a dedicated, committed all-out effort to abolish drugs in the United States? Is this a war on drugs or is this just a shuffling of statistics and contention to make reanalysis?

Dr. GOODWIN. I myself don't favor the term "war," but if we take the one analogy that's closest to it, the war on cancer——

Mr. GUARINI. What word?

Dr. GOODWIN. Well, I think it should be called a sustained comprehensive campaign. But putting aside those words, the other war that we've had in this country was a war on cancer. I'd like to point out that Congress has had appropriate patience with the war on cancer in terms of the changes in death rate. We have seen considerable advances in the area of childhood leukemias, lymphoma and Hodgkin's Disease, which came 5 to 7 years after that research war. In that case the research war was started in 1972.

We have, I think, begun to see some of the changes from the prevention campaigns in the drug abuse "war." It's not nearly enough and there are wide differences and perceptions about the nature of the problem. That's why we need data, that's why we need statistically valid samples so that every action that we take——

Mr. GUARINI. So, it's certainly not a war. It's not an all out effort. That's not——

Dr. GOODWIN. No; I——

Mr. GUARINI. It's a sustained effort to try to reduce and contain the drug problem within the United States. This is what I seem to gather from the sense of the meaning today.

Doctor GOODWIN. Yes; I think it's a sustained all-out effort. But it's an effort in which many of the components have only recently been put into place. I think that in looking for results of those very recent, fresh efforts, it is still early to be expecting the results just as we do not demand that the National Cancer Institute stop its efforts because they haven't cured breast cancer or colon cancer or many of the killers in this country. These are long-term complicated health problems. This one is particularly complicated because it's embedded in our social structure. Lots of problems in our inner cities and our under-class with education——

Mr. GUARINI. So in the last 10 years, Doctor, we've been making a sustained effort and we're still really no further ahead——

Dr. GOODWIN. I would say in the last 2 years——

Mr. GUARINI [continuing]. Than we were 10 years ago. I was just wondering whether or not we're serious in going all-out to get rid of this drug abuse?

Dr. GOODWIN. The current players that you're talking to really have been involved in this effort for the last 2 years. Doctor Bennett's ONDCP and Congress' initiatives in this, we're really talking about the reinvigoration of an effort which we all historically can say was inadequate in the past. We agree with you on that.

Mrs. LOWEY. Let me just say in closing, that it was very surprising to me that even though this was a recent study, that we're just beginning to understand that we must address the many factors which contribute to drug abuse. Many of us who have been out there in the community, in community action programs and drug prevention programs, have known for many, many years and have read many, many studies that it's the root causes of poverty, housing, homelessness, family breakups, lack of child care, teenage pregnancy, et cetera that leads to drug abuse. But, okay, if you're just discovering it now, a couple of weeks ago you said, and it's confirmed once again, let's hope that we can act on it now.

Dr. GOODWIN. The discovery was how to link them, not that they were——

Dr. JOHNSON. The research confirmed what we thought. If you look at the demonstration grant program that Congress enacted in 1986, but actually began in 1987, you will see that those programs emphasized community linkages. NIDA research projects have supported the direction we have taken. Without demonstration projects since 1987.

Mrs. LOWEY. Well, I'm delighted that these findings have been confirmed and I look forward to working with you to finally get the resources and to get the direction to make sure that we act on the confirmation.

Thank you very much.

Mr. SCHEUER. Thank you.

Doctor Goodwin, I find it remarkable that you could say at this late time, at this late day and age in June 1990 that we need data, we need statistically valid samples, we need to engage in a sustained all out effort. You worked in the Reagan administration. I mean, where have we been all of these years that in June 1990 you're decrying the need for more data, for more statistically valid samples?

This committee, this Select Committee on Narcotics has been in business since the 1970's and I've been on it ever since then. We've been talking to you, talking to the Reagan administration people, of which you were a member, talking to the Bush administration people, of which all four of you are members. I note for the record that President Bush was the top banana in the drug war during the Reagan years. He was the point man in the Reagan administration. How can there be so little institutional memory, that you can sit here today and say we need more data? Why in the heck hasn't that data been collected? Why in the heck haven't you produced statistically valid samples? I mean, I find this aberrational.

You talk about the need for comprehensive sustained all out programs, when this administration has refused—well, this administration has produced what they call a minimum methadone maintenance program with virtually no counseling or rehabilitation services. I mean, that is the antithesis of everything that everybody—the consensus that all of the Members agree on today from one end of the political spectrum to the other. You yourself have said that. But in your own funding you come up with this pitiful, absolutely pitiful stripped-down methadone maintenance program where you ignore all the needs of that young person except to give him a substitute for heroin.

Dr. GOODWIN. In fact, in terms of the methadone part, the so-called stripped down version we have not approved of that. Doctor Primm and Doctor Schuster can talk more about that.

In terms of your initial comment about data, my point is——

Mr. SCHEUER. You haven't withdrawn it, have you?

Dr. GOODWIN. Yes; it has been withdrawn.

Mr. SCHEUER. It has been withdrawn. As of when was it withdrawn?

Dr. GOODWIN. The interim proposal has been withdrawn.

Mr. SCHEUER. As of when? Wait a minute, as of when was it withdrawn, Doctor Schuster?

Dr. SCHUSTER. The decision to withdraw was made about 4 weeks ago. We concluded on the basis of the comments that were made regarding the suggested proposal, which I will go back to in a moment, that we would not promulgate that regulation. FDA is going through the process of putting that into the legal language, but it is rescinded.

Dr. GOODWIN. My general point about——

Mr. SCHEUER. On sober second thought, you really felt that was a very barren and unproductive approach——

Dr. SCHUSTER. That's right. Let me just say that if I had a person come into the methadone maintenance program on Friday evening, salivating in withdrawal and I could not admit him, I think that the 2 to 3 weeks until they could get into a comprehensive program to provide them with methadone is medically sound and humanitarian.

Mr. SCHEUER. I totally agree with you. But I think——

Dr. SCHUSTER. That's what the interim methadone maintenance program was supposed to do.

Mr. SCHEUER. I'd think you'd want to do something Monday morning with that young person. If you tided him over the week-

end, I think Monday morning you would want to begin counseling with him and find out——

Dr. SCHUSTER. That would be a truly ideal type of treatment.

Mr. SCHEUER. Yes; it would be ideal. It seems to me at a time and place in our history when we're prepared to spend $300, $400, $500, $600 billion on our savings and loan debacle that we should be willing to spend more than $3 billion on education, on treatment, on rehabilitation and prevention. That's about the order of magnitude of what we're spending now. It's a bloody disgrace. It's a bloody disgrace.

You know darn well, all of us know, that we're going to find the money for that other war, the war to bail out the investors in these S&Ls. We have a national obligation to do that. It's going to cost us $500 billion and it may cost us closer to $1 trillion before we're done. We recognize that as a legitimate challenge to our country.

Mr. COUGHLIN. Mr. Chairman——

Mr. SCHEUER. Why the heck can't we recognize the problems of 10 million plus young people who are involved in addiction and the causes why they're involved in addiction, the education deficit, the way we're failing young people in our country, and you pointed that out, Doctor Goodwin? Why can't we recognize that as equally important and equally place in our priority's list next to the investors in the failed savings and loan banks and institutions?

Mr. COUGHLIN. Mr. Chairman, could I just comment——

Mr. SCHEUER. I'd rather not. I'm asking a question. You had a very long count before, Congressman.

Mr. COUGHLIN. You've had your second round, could I have a round when you're through?

Mr. SCHEUER. Well, of course. I'm waiting for them to answer my question. I will, of course, recognize you.

Dr. GOODWIN. I want to comment on the issue of data collection and knowledge generation. I think, just as with other health problems, it's very important to not fly blind. It's very important that in a complicated problem, as we tackle the problem, we don't go only on our hunches about what we're——

Mr. SCHEUER. Doctor Goodwin, nobody disputes that. What I'm suggesting is that it's long past due when a top representative of the administration should come before this committee and say we need really sound solid, scientific data. Why didn't we talk about this a decade ago or a half a decade ago?

Dr. GOODWIN. That statement should be true today and true a decade from now and a decade ago. That's just the general principle. It's important for me to point out as a scientist that we need data to design programs——

Mr. SCHEUER. You always need data, but you're not ever going to know everything. To delay doing anything until you know everything is a total exercise in futility.

Dr. PRIMM. Mr. Chairman——

Dr. GOODWIN. That's clearly not what we're doing. In fact, the——

Mr. SCHEUER. Well, when you're leaving 10 million people unattended and uncared for and their needs unaddressed and you're 1½ million and you're ignoring the other 10 million, it seems to me that comes pretty close to what you're doing.

Dr. GOODWIN. You can discuss the differences in the magnitude. All I want to point out is that our treatment programs and our prevention programs have expanded substantially faster than our research and data collection programs. That is to say, most of our new drug money has gone into treatment and prevention. Some of it has gone into trying to learn more about what works.

Mr. SCHEUER. What I'm suggesting is that the money that you have put in, whatever the mathematical increase, has been at such a trivial level that the mathematical increases, whether it's 100 percent or 200 percent, are meaningless because you're still spending a total of about $3 billion on education, treatment, prevention and rehabilitation. You would be spending $400 billion or $500 billion on the S&Ls to bail out those security holders. Why can't we put drug addiction on that same level of priority and spend whatever it takes to make it an impact on this problem?

Talk about education, you have a very excellent brochure that the Department of Education produced about a year ago. I reproduced it and sent it out in my newsletter to my whole district. The reason that I did that because you weren't distributing it. You were sending it to a school principal. I never understood that they were a part of the problem. But you weren't giving it to teachers, you weren't giving it to parents, you weren't giving it to kids. The whole education effort—if it weren't so tragic—would be a joke.

The painful, minuscule impact that the federally led education effort has had on this greatest source of education failure—it's less than 1 percent of the budget of the Department of Education, addressed to the one thing that is the killer of the education dream of young kids. Your investment in health is about 1 percent of the total health budget of this country when it constitutes, when drug constitutes a major threat to the health of our people, including the whole business of shared needles which drives the AIDS epidemic in this country that is ravaging our population, particularly our low-income and minority population. What I'm suggesting is that it really doesn't help matters when you're saying you double something that went from $200 million to $400 million when actually we ought to be spending up in the tens of billions of dollars to address this problem that is destablizing life in America, destablizing urban life in America, producing an under-class in our society of kids who can't make it, haven't made it, and are never going to make it, who will never have a respectable job in their whole lives because they've been ignored. The whole noncollege bound youth population in our country is being painfully under served and the dropouts are being painfully under served and the drug addicted dropouts are being even more painfully under served. It's absolutely pitiful.

Congressman Coughlin from Pennsylvania.

Mr. COUGHLIN. Thank you, Mr. Chairman.

I guess I take very strong exception to some of the statements that have been made. Congress is, after all, the organization that appropriates the money to fight the drug war. We are marking up our bills today to the budget requests made and approved by the House of Representatives which, as you well know, is controlled by the Democratic Party.

Mr. SCHEUER. You're right. Let me just say——

Mr. COUGHLIN. Well, wait a minute.

Mr. SCHEUER. Let me just say one sentence. The increases that Doctor Goodwin talked about, 200 to 400, 500 to 900, were mostly insisted upon by the Congress. They weren't asked for by the administration.

Mr. COUGHLIN. No; that's not correct, Mr. Chairman. That is simply not correct. The administration has requested and we've had increases in the drug funding at the President's request of almost 80 percent. If I look at Doctor Johnson's program, which has grown from $3 million in 1986 to $155 million in 1990. That's a pretty doggone significant increase.

Now, let me touch on a couple of other things, because you had some time. Let me just take some time on these topics.

It's been talked about not having good drug programs in our prisons. But the fact is that Congress didn't pass the legislation the President asked for to have drug programs in our prisons. That's one reason why we don't have it.

It's been said that we don't have good drug abuse education programs in our schools. But Congress did not pass the legislation requiring drug abuse education program in our schools until last November. We're just putting out the regulations now. It's just being implemented. The people before us are not in charge of that, that's another department of the federal government, but that's important.

It's been talking about the fact that we're not utilizing military bases and under utilized Federal facilities. But the Congress required that the first priority in the use of those facilities be the wrong ones, not for drug abuse or not for prison.

So it's not just a question of the people who are sitting before us who are responsible for a particular part of what is going on in the drug war, I'll call it a war, because it is a war, they're doing a lot of activity.

If I remember what happened a year ago when you appeared before us, there wasn't half what's going on that is going on now. I know, you know, and we in this committee know that you don't find cures for diseases overnight, and that's exactly what this is. You have to have time. These are medical, clinical issues that we're talking about, Mr. Chairman, that have to be looked upon like that.

I just want to say for my part, congratulations on what you're doing. Congratulations on the progress you've made. Congratulations on the great effort you're putting forth and, I might say congratulations to the Congress on having appropriated more money to allow you to do just that.

Mr. SCHEUER. All right, Congressman Guarini of New Jersey.

Mr. GUARINI. I want to commend the professionals here, even though it seems at this moment that they may be "beating" up on you. It really stems from the frustration here. We're all part of the same team.

I don't want to have the impression created that we aren't appreciative of the efforts you're making. You can only deal with the resources that you have. I just think it's pitiful for the last 8 years—not the last 8 years, for the 8 years under Reagan's administration

that there were cut backs, that there was not a serious effort nationally to devise a drug policy.

The educational program was $3 million for tens of millions of students. It was not recognized that there was a national need out there. The leading effort was, "Say no to drugs." It was pitiful. That's why we're in the position that we're in now.

Since President Bush has taken charge, he's appointed a Drug Czar. He has done a number of things. He has shown a serious effort to attend to the problem. I want to commend him for the efforts that he's making, but I still want to assess the situation correctly and say that the Reagan years were pathetic. I think that President Reagan gave us this drug legacy that we have today.

That's my personal opinion, but I think that the record would bear a great deal of it out.

We didn't have a curricula. Law enforcement was supposed to be a strong hand. That was the way we were supposed to address the problem. I just want to state that you, ladies and gentlemen, are really in the front lines and the trenches and you're fighting a very difficult problem.

Let me just ask you, in regard to the mix of how we are spending our money, since you're in charge of drugs, mental health, and the AIDS problem that we have. We have just spent $3 billion or appropriated $4 billion for this coming year for AIDS. Congress has just passed those bills. Do you feel that we are wisely spending the moneys that we've appropriated to give the particular emphasis in distributing the money towards these special programs that deal with the health of our country? Is the mix proper in your opinion?

Dr. GOODWIN. If you're talking about the entire health spectrum——

Mr. GUARINI. That's right.

Dr. GOODWIN [continuing]. That's a very complicated question.

Mr. GUARINI. Well, of course, substance abuse, alcohol and drugs, which you've mentioned, AIDS, of course, which is an outgrowth of the——

Dr. GOODWIN. In terms of the——

Mr. SCHEUER. Excuse me; their reach would also extend to Head Start—it's their responsibility.

Mr. GUARINI. Are we spending our money in a wise distribution? Are our resources put in their proper priority perspective? Now, knowing that we need more money for all the programs, are we intelligently addressing the resources that we're spending at this time?

Dr. GOODWIN. I could best address that with respect to my own areas of responsibility. As you said, for alcohol, drug abuse and mental health on the demand reduction side, because ADAMHA is the principal demand reduction agency.

I think that the fact that the drug abuse portion has grown faster than the alcohol and the mental health portions is appropriate to the national crises that we're in. I think that the main plea I would have with Congress is to maintain the maximum flexibility for professional and scientific leaders to shift if we have to, because we find that, as Doctor Primm said, that the nature of the problem can change from year to year or even month to month.

We've learned, for example, that 65 percent of people entering drug treatment have a coexisting psychiatric disorder, a mental illness or mental health disorder. The ability to treat these people by mental health specialists—who are not very plentiful in the drug treatment system—the ability to treat them properly is linked highly to the efficacy of drug treatment.

Second, I would go back to my plea to keep our eye on the long term while we deal with the short term. The drug abuse treatment system has had knowledge gaps. There have been lots of people in it who have worked in a very dedicated way, but along the way we haven't done—way back in the 1960's and 1970's—some of the tough minded comparative studies to say does this enthusiastically pursued treatment approach really work? Does A work better than B and so forth. We need to do those kinds of studies now. There is some catching up we have to do there, because the worst tragedy would be to put in place, lock in place, programs that are of only modest efficacy.

So, I'm concerned about keeping the balance between delivering treatment, promoting prevention and studying and researching the problem, just like we do in other areas of health.

Mr. SCHEUER. The gentleman's time has expired.

Congressman Shays?

Mr. SHAYS. Thank you. I would feel very guilty if I didn't say very bluntly that in no way would I want to be associated with any remarks that blamed the administration for the drug problem. I happen to think the drug effort is a disgrace, but I think it is a disgrace shared equally by the administration and Congress. We have every right and ability to appropriate any sums of money we choose to.

So I just want to be on record of that.

But I would like to learn something more specific than some of the generalities I'm hearing. I've read the statement of Mr. Sullivan. I read that in 1988 we had 14 million people who experimented with drugs and that we had approximately 7.6 million who were heavy users—in other words, using drugs 50 times. We had 4 million who were core users, using drugs 200 times.

Of these 14 million people—I guess we have some lesser number—now, how many are receiving rehabilitation programs? How many have gone into rehabilitation programs and what is the number increasing by? What percent are receiving more? Are 1 million people receiving treatment, or what's the number?

Dr. GOODWIN. We estimate around 1.2 million, something in that order.

Mr. SHAYS. So, of the heavy users and the core users, of which there are 11 million, 11.6 million, you think about 1.2 million are receiving treatment?

Dr. GOODWIN. Well, we're focusing on the addicted now, which we estimate at 4 million.

Mr. SHAYS. Those are the 4 million. OK; so we are reaching about 25 percent.

Now, is the problem that we simply cannot put enough money into the system and spend it wisely? Or what's the challenge for us?

Dr. GOODWIN. Two challenges. First, what is the number of people who will accept treatment, which we estimate at between 25 and 50 percent? Second, is there a finite rate at which you can expand the system; that reflects the need to train personnel? There is an obvious shortage of qualified professionals and paraprofessionals in these fields.

Mr. SHAYS. I want to go on record with you as saying I am aware of a number of constituents in the Fairfield County area right next to Nita Lowey's Westchester that simply want to be in programs and can't get in.

Dr. GOODWIN. Sure.

Mr. SHAYS. I mean, we do case work trying to get people into programs and sometimes I feel all we've done is get our person in, and someone else didn't get in who probably was just as deserving.

Dr. GOODWIN. There's no question that that exists. There's no question also, as Doctor Primm said, that there are, in fact, centers that have vacant spaces——

Dr. PRIMM. There are a number of barriers to creating treatment programs, not the least of which is community resistance to the creation of those programs. But not only that, to find personnel to staff the programs. We need to beef up the training of people and get them interested in staffing the programs. You just can't throw money out——

Mr. SHAYS. Let me interrupt you then, because I agree with you. I know what you're saying. I think your point is valid. How long is it going to take us to get up to the 2 million figure which is approximately 50 percent of the 4 million who want treatment? How long will that take?

Dr. GOODWIN. If the States continue to do their fair share, that's an issue that may need to be addressed in the State treatment plans—if the States continue to do their fair share, we ought to be at a full system in a couple of years. That's——

Mr. SHAYS. A couple of years is 2 years to me.

Dr. GOODWIN. Two.

Mr. SHAYS. Okay. Let me just then go quickly to education. How many of the young people are we reaching—10 percent, 20 percent, 30 percent, 40 percent, 50 percent? In other words, this education program to stay off drugs, which is working, how many of these young people are we reaching? I realize there's the core group in the urban areas and there's the suburban young people.

Dr. GOODWIN. We can only speak to the number that are reached through our programs. Of course, the Department of Education has larger programs than we, in this general area.

Do you have those data, Doctor Johnson?

Dr. JOHNSON. I have some. In looking at information derived from our programs last year, we reached close to 100,000 people, through training and primary prevention.

The numbers are smaller in terms of direct care and direct intervention because we had a small number of grants in 1989. However this year our program has grown significantly; therefore, we expect to reach a far greater number of people with our core program. I should point out that our core program includes technical assistance, training, primary prevention, and direct services. So it's a comprehensive set of services that I'm talking about.

Mr. SHAYS. OK; it strikes me as a small number, but your message to me is HHS does not have the primary responsibility in education.

Dr. JOHNSON. No; because the Department of Education has about $500 million of the drug-free schools program. That's over and beyond our budget of approximately $200 million.

Dr. GOODWIN. She's talking about the high risk programs. In other words, the programs that Mr. Scheuer was talking about, the kids that are hard to reach. Therefore, the numbers are smaller and the programs are more intensive.

If you just take the mailings out of ONDCP, 15 million drug information packets went out last year. That's a lot. But those are not the same as the comprehensive prevention programs. These high intensity programs——

Mr. SCHEUER. Are these high risk kids that you're talking about in school or out of school?

Dr. GOODWIN. Both.

Dr. JOHNSON. Both.

Mr. SCHEUER. You're trying to reach the out of school high risk kids, the dropouts——

Dr. JOHNSON. The Congress specified that our programs focus on high-risk populations, including our children who are having problems in school, but who have not dropped out as well as those who have dropped out.

Mr. SCHEUER. Right.

Dr. JOHNSON. As well as those in gangs.

Mr. SCHEUER. Congressman Mfume?

Mr. MFUME. Thank you, Mr. Chairman. I will attempt to be brief. I know we are faced with time problems.

I need to raise the level of this discussion to something new and different and, perhaps, to glean individually from all of you your own gut reaction to the comments that were made by Secretary Sullivan in Boston on June 6th at the Symposium on Drug Abuse and Birth Defects, which had been widely reported in "The Boston Globe, The New York Times" and in the "Washington Post" where Secretary Sullivan said essentially that pregnant women who use illicit drugs are, in fact, committing child abuse and that parental rights should be taken away in the more serious cases. The implication being that prosecution could, in fact, occur if, in fact, we adopt this kind of policy nationwide.

Needless to say, there has been a great deal of reaction. Public health officials have gone so far as to call that suggestion a ridiculous and grotesque public health policy.

The irony, I think, in all of this is that most programs, treatment programs, refuse to accept pregnant substance abusers. So it seems to me that the Secretary in his own way has tried to bring a different level of concern or action, certainly, to this problem. However, those in that target group, because of current policy, are in a dilemma.

Could each of you individually, without speaking for the Secretary, or trying to second guess his remarks, share with this committee your own feelings concerning treatment given in this Nation to any pregnant woman who abuses drugs possibly commit-

ing child abuse and the suggestion also that parental rights in the society in those cases be taken away?

Dr. GOODWIN. Let me start by first saying, briefly, that I am aware that the Secretary was somewhat chagrinned at the relatively selective reporting of his overall comments and overall remarks at that particular setting. Indeed, in his speech as I've seen it there were many, many other comments about the need for more treatment programs for women, and there were many comments about the need for voluntary treatment. He mentioned specifically that this was a last resort kind of measure. It did certainly draw immediate attention to that issue and, perhaps, Doctor Primm and Doctor Johnson in particular could talk about the number of activities that are going on in this area.

I don't know if you saw the Nightline program last night which addressed this issue, but, to me personally, one of the most convincing people on that program was a young addicted woman who felt that had it not been for some tough realities of law enforcement, she would not have entered treatment. She felt that she's not like the upper-middle-class lawyer or doctor drug abuser who has a lot to lose and all you need to do is point out what's going to happen to their career, their marriage or their reputation. She was in a situation where she didn't have much to lose. For her, having some negative consequences in a legal sense was very important for getting her to do something she didn't want to do. A lot of people with drug problems, in fact, don't want to go into treatment. These court threats provide some negative impetus.

[Dr. Goodwin's answer precedes the following written answers given for the record.]

DR. SCHUSTER, DIRECTOR, NATIONAL INSTITUTE ON DRUG ABUSE

Fear of potential legal sanctions associated with drug abuse during pregnancy (e.g., being charged with child abuse leading to incarceration and/or losing custody of one's child or children) may constitute a formidable barrier to treatment. Women may avoid situations that require drug screening, diagnostic procedures, or testing which may threaten their sense of privacy and self-determination, custody of their infant and/or other children, or place demands on them beyond their emotional and life support system resources.

DR. JOHNSON, DIRECTOR, OFFICE FOR SUBSTANCE ABUSE PREVENTION

Our outreach efforts have found that sanctions are only marginally successful at changing behavior, albeit, for certain individuals, the fear of punitive action will force them to face their need for treatment. However, OSAP views access to services as a valid method of preventing babies from being born drug affected. It is clear that there are numerous practical barriers to services for pregnant women, such as transportation, child care, and program liability concerns. It is through aggressive outreach efforts that OSAP grantees have been able to break down some of these barriers.

DR. PRIMM, ASSOCIATE ADMINISTRATOR, OFFICE FOR TREATMENT IMPROVEMENT

Issues to consider in terms of either criminal prosecution or in keeping a child with its natural mother include:

Research findings indicate that when the maternal medical and obstetrical complications seen in drug dependent mothers are treated, the medical outcome for the neonate is similar to that obtained for drug-free mothers of the same socio-economic status and ethnic class.

Drug and alcohol addicted women contribute the most to perinatal morbidity and mortality in the U.S. and are the least likely to seek and receive proper prenatal care. Criminalization may exacerbate this situation further.

The bonding between the child and its natural mother that is established immediately after birth by repeated contact is fragile and has been found to underlie successful parenting. Every effort, therefore, should be made to keep mother and child together during this period.

Therapeutic outcomes for the mother are often enhanced if a stable relationship can be maintained with her children.

A drug-dependent parent who has been successfully treated is often more tolerant of the aberrant behavior of a drug-affected infant than either fostercare or extended family members.

Drug treatment outcomes have a direct positive effect on child welfare.

Health professionals, particularly those treating high risk pregnancies have been difficult to recruit into treating addicted women. Criminalization and the role that health professionals would be expected to play, may result in their further withdrawal from caring for this population.

Women of childbearing age who use illicit substances are often already weakened by unemployment, illiteracy, homelessness and legal issues. Criminal prosecution may further exacerbate their recovery.

Finally, the impact of such a policy would have serious consequences for an already overburdened fostercare and youth services system within the States.

In lieu of criminal prosecution, public health approaches should be considered including intensive outreach, visiting nurses and other forms of mobile services, and even civil commitment to specialized treatment.

Mr. MFUME. What I wanted to ask is, and indicate also that I've not prejudged the Secretary's comments. I think they deserve some attention. Obviously, now that it is part of the public record, it will get that. But I thought that individually some of you may have some sort of reaction yourself.

Dr. GOODWIN. Perhaps Doctor Primm would comment on this since he's been particularly interested in the program; and Doctor Johnson also who has many of the program responsibilities for the pregnant/postpartum——

Mr. SCHEUER. Excuse me. The time of the gentleman has expired. Congresswoman Lowey?

Mr. MFUME. Mr. Chairman, if I could ask unanimous consent that the responses to the questions be made a part of the formal record.

Mr. SCHEUER. No objection; so ordered.

Mr. MFUME. Thank you.

Mr. SCHEUER. We would welcome that.

Mrs. LOWEY. I'll be very brief because I do know we want to close this hearing and I want to thank all of you. I appreciate your commitment and I know we all understand of each other's frustration and we all want to reach the same goal. I just hope that together we can do it more quickly than, perhaps, we've even discussed today.

In particular, I'd like to pursue the use of these military bases. Perhaps in light of your statement that the priority uses were housing, prisons and drugs; perhaps we can make multiple uses if these bases, because those very compilations are those that have the most serious problems. I would hope that we can explore that, because I think these are facilities, they have the equipment and they have the personnel.

In many of schools, in fact, in our educational programs, especially our adult educational programs, we are currently using systems that are quite professional and quite skilled that really have been created in the Army. I'm sure that there are many facilities and many personnel that are currently being employed in the military that could then be transformed or used to fight in this war.

I know our time is late, but I'm hoping that we can pursue that, unless you have a quick comment about multiple uses that are already in place. I don't know if that's happening.

Dr. GOODWIN. Only to reaffirm what you said, that clearly the homeless, drug abusers and prison populations are multiple and overlapping populations.

Mrs. LOWEY. Exactly.

Dr. GOODWIN. So it makes some sense to try to do that.

Mrs. LOWEY. So that the priorities that are given are really irrelevant because they certainly can be used in a comprehensive way.

Dr. PRIMM. Approximately 36 percent of the people going into the Job Corps are also affected by drug abuse, and we now have an initiative that we are trying to formulate with the Job Corps in order to do training and treatment there. So what you have suggested is a way to impact where people are located who are involved in this problem. We can confer on those things after——

Mrs. LOWEY. Well, thank you. I look forward to working with you and, hopefully, we can make progress. Thank you very much.

Mr. SCHEUER. Just a footnote on the point that Mrs. Lowey was making before. I think it was you, Doctor Goodwin, who said that there was a reserve training facility that was being hungrily looked at by the drug community for treatment programs, but that it was used 4 weeks in the summer. It seems to me that where that's true, there ought to be some real jawboning between the Secretary of HHS and the Secretary of Defense. For goodness' sake, free up that facility and whether it's for use by the homeless or whether it's for prisoners or whether it's for drug prevention programs, use that facility for goodness' sake, for 52 weeks a year and not let the Defense Department tie it up 48 weeks a year because they're using it for 4 weeks over the summer.

Great. Well, so we're ending up on a positive and constructive note.

Let me thank the four of you for your very forthcoming testimony today. We all respect the work that you're doing. We all respect your bona fides. There is a very high frustration level here on both sides of the aisle, as you can see. But that will probably always be with us. We're never going to achieve simple antiseptic solutions to this problem, but we thank you for your fine testimony.

Mr. COUGHLIN. Let me join in thanking the witnesses. They're true professionals and we appreciate your service and work.

Mr. SCHEUER. The meeting is adjourned.

[Whereupon, at 12:19 p.m. the committee adjourned subject to the call of the Chair.]

OPENING STATEMENT OF THE HONORABLE JAMES H. SCHEUER

GOOD MORNING, LADIES AND GENTLEMEN.

THE SELECT COMMITTEE ON NARCOTICS ABUSE AND CONTROL CONVENES TODAY TO ONCE AGAIN GET AN UPDATE FOR THE AMERICAN PEOPLE ON THE PROGRESS THAT OUR GOVERNMENT IS MAKING IN THE WAR ON DRUGS. TODAY, WE WILL HEAR FROM ONE OF OUR DISTINGUISHED CABINET SECRETARIES, THE HONORABLE DR. LOUIS SULLIVAN, WHO IS THE SECRETARY OF HEALTH AND HUMAN SERVICES.

AS YOU KNOW DR. SULLIVAN, OUR COMMITTEE HAS WORKED DILIGENTLY OVER THE YEARS TO HELP SHAPE THIS NATION'S DRUG CONTROL POLICY. WE HAVE PUSHED FOR A GREATER ROLE FOR OUR CABINET SECRETARIES IN HELPING THE PRESIDENT, AND NOW THE DRUG CONTROL POLICY DIRECTOR, DEVELOP A BATTLE PLAN THAT WOULD RID OUR NATION OF THIS AWFUL SCOURGE.

THIS IS NOT THE FIRST TIME THAT DR. SULLIVAN HAS APPEARED BEFORE THE SELECT COMMITTEE, AND HOPEFULLY IT WILL NOT BE THE LAST. AS ALWAYS, MR. SECRETARY, WE LOOK FORWARD TO GETTING YOUR INSIGHT INTO THIS NATIONAL TRAGEDY. WE ANTICIPATE HEARING FROM YOU ABOUT THE INITIATIVES THAT YOUR DEPARTMENT HAS PUT TOGETHER TO HELP STEM THIS DANGEROUS TIDE THAT POSES A THREAT TO OUR FUTURE AND OUR NATIONAL SECURITY.

I WOULD HOPE, MR. SECRETARY, THAT, AS THE NATION'S CHIEF HEALTH AFFAIRS EXPERT, YOU AND YOUR STAFF ARE WORKING TO IDENTIFY AND CORRECT THE MANY PROBLEMS THAT PLAGUE OUR TREATMENT SYSTEM.

EVERY TIME SOMEONE BRINGS UP THE NEED FOR TOUGHER LAW ENFORCEMENT AND ADDITIONAL RESOURCES FOR FEDERAL, STATE AND LOCAL POLICE AGENCIES TO BATTLE THE DRUG CRISIS, THE RETORT IS THAT WE NEED TO FOCUS MORE ON PROVIDING QUALITY TREATMENT FOR AS MANY PEOPLE AS WE CAN. SOMEONE ALWAYS MENTIONS THE NEED TO FOCUS ON DEMAND AND BUILD TOWARDS TREATMENT ON DEMAND. AND YET WITH THE LIMITED NUMBER OF TREATMENT SPACES THAT WE HAVE IN THIS COUNTRY NOW, WE ARE STILL UNABLE TO DO A DECENT JOB IN THE REGULATION AND PROVISION OF TREATMENT SERVICES.

- THERE IS NOT ONE SINGLE FEDERAL TREATMENT CENTER IN THE ENTIRE COUNTRY. THERE IS LITTLE, IF ANY AT ALL, ACCOUNTABILITY FOR THOSE WHO RUN TREATMENT PROGRAMS. THERE IS NOT A SET OF NATIONAL STANDARDS BY WHICH TREATMENT AND TREATMENT PROVIDERS SHOULD BE JUDGED.

I HOPE TODAY THAT WE WILL HEAR FROM YOU AS TO HOW WE CAN IMPROVE OUR TREATMENT SERVICES , AS WELL AS HOW WE CAN EXPAND THESE SERVICES TO INCLUDE MORE PEOPLE WHO WOULD BENEFIT FROM THEM. THE CASUALTY LIST IS GROWING AND SO SHOULD OUR RESPONSE.

DR. HERBERT KLEBER, WHO IS THE TOP TREATMENT OFFICIAL WITH THE DRUG CONTROL POLICY DIRECTOR, INDICATED TO OUR COMMITTEE IN TESTIMONY LAST YEAR THAT OUR TREATMENT SYSTEM IS ONLY SUCCESSFUL ABOUT 20 PERCENT OF THE TIME. IN OTHER WORDS, FOUR OUT OF EVERY FIVE DOLLARS SPENT ON TREATMENT ARE INEFFECTIVE. TO ME, THAT SHOULD BE OUR CALL TO ARMS ON THIS ISSUE.

THERE IS ANOTHER PRESSING PROBLEM THAT IS DEVELOPING RAPIDLY IN THE BACKGROUND AS A RESULT OF OUR NATION'S DRUG CRISIS. THE ALARM BELLS HAVE GONE OFF IN OUR NATION'S EMERGENCY ROOMS, ESPECIALLY IN LARGE INNER CITY HOSPITALS, MR. SECRETARY.

I HOPE TODAY THAT YOU WILL HELP GUIDE US TOWARD A SOLUTION TO THE PROBLEM OF THE OVERWHELMING NUMBER OF DRUG OVERDOSE VICTIMS AND DRUG SHOOTING VICTIMS WHO ARE BEING WHEELED INTO THE NATION'S EMERGENCY ROOMS IN RECORD NUMBERS, NUDGING OUT THE ACCIDENT VICTIMS AND THOSE SUFFERING WITH HEART ATTACKS AND OTHER TRADITIONAL MEDICAL EMERGENCIES. THERE IS A TUG OF WAR GOING ON FOR PRECIOUS STAFF AND SERVICES.

THE CRISIS REGARDING EMERGENCY ROOMS AND DRUGS VICTIMS PROMISES TO BE OUR NEXT DRUG-DRIVEN PUBLIC HEALTH STRAIT.

WE KNOW THAT THE DRUG-RELATED AIDS CRISIS HAS NOT ABATED. AND WE KNOW THAT THERE IS A GROWING NUMBER OF BABIES COMING INTO THIS WORLD INFECTED WITH THE AIDS VIRUS AND ADDICTED TO

DRUGS THROUGH NO FAULT OF THEIR OWN. WE NOT ONLY HAVE TO TREAT THE BABIES --- OFTEN FOR THE REMAINDER OF THEIR LIVES --- BUT WE MUST FIND A WAY TO DEAL WITH THE MOTHERS' DRUG ABUSE AS WELL. YOU HAVE RECENTLY SUGGESTED CRIMINAL SANCTIONS FOR PREGNANT SUBSTANCE ABUSERS. BUT THE SIMPLE TRUTH IS THAT TREATMENT IS NOT AVAILABLE EVEN FOR THE PREGNANT WOMEN WHO WANT IT, AND I DO NOT SEE WHERE THE FEDERAL GOVERNMENT HAS MOVED TO MEET THESE SPECIAL NEEDS BEFORE THEY OVERWHELM US, MR. SECRETARY.

IN TOO MANY CASES, MR. SECRETARY, OUR TREATMENT SYSTEM ADDRESSES THE SUBSTANCE ABUSE ONLY, WITHOUT ANY REFERENCE TO THE UNDERLYING ROOT CAUSES THAT WOULD LEAD ONE TO EXPERIMENT WITH AND BECOME ADDICTED TO ILLEGAL DRUGS.

WHAT GOOD DOES IT DO US TO TEMPORARILY STOP A PERSON'S DRUG ABUSE, IF, AFTER THEIR DISCHARGE FROM TREATMENT, THEIR ONLY OPTION IS TO RETURN TO ILLICIT DRUGS BECAUSE WE HAVE NOT GIVEN THEM ANYTHING ELSE?

WE NEED TO TAKE INTO ACCOUNT THE ROLE THAT UNEMPLOYMENT AND UNEMPLOYABILITY, ILLITERACY, INADEQUATE HOUSING AND LACK OF HOPE AND OPPORTUNITY PLAY IN THE PERPETUATION OF OUR DRUG PROBLEM.

IN INFORMATION FORWARDED TO OUR COMMITTEE FROM THE OFFICE OF SUBSTANCE ABUSE PREVENTION, WE FIND THAT OSAP HAS COME TO THE CONCLUSION, AFTER RESEARCH AND STUDY THROUGH ITS DEMONSTRATION GRANTS, THAT TO GET A PREVENTION MESSAGE THROUGH TO AN INDIVIDUAL, FAMILY OR NEIGHBORHOOD, YOU FIRST HAVE TO PROVIDE SOCIAL AND EMOTIONAL SUPPORT AND MEET BASIC NEEDS FOR FOOD, HOUSING, PHYSICAL SAFETY AND JOBS.

MR. SECRETARY, I SAY THAT WE REALLY DID NOT HAVE TO WAIT ON OSAP TO TELL US WHAT WE ALREADY KNOW. I HOPE THAT WE HAVE ALREADY BEGUN MOVING IN THE DIRECTION OF FINDING A WAY TO PROVIDE AND DEVELOP MORE COMPREHENSIVE DRUG PREVENTION AND TREATMENT IN THIS COUNTRY.

IN A GAO REPORT RECENTLY COMPLETED FOR THE SELECT COMMITTEE, WE HAVE LEARNED THAT METHADONE TREATMENT IS NOT REALLY EFFECTIVE UNLESS IT IS ACCOMPANIED BY SERVICES THAT TAKE THE OVERALL NEEDS OF THE INDIVIDUAL INTO ACCOUNT.

WE NEED TO FIND A WAY TO TREAT COCAINE AND CRACK ADDICTION. OUR GOVERNMENT NEEDS TO EXPLORE WHAT TREATMENT PROGRAMS WORK, AND WHICH ONES DO NOT WORK.

WE ALL KNOW THAT DR. BENNETT, AS DRUG CZAR, IS THE LEADING ADMINISTRATION SPOKESMAN ON THE DRUG ISSUE. BUT WHEN IT COEMS TO THE HEALTH AND SOCIAL ASPECTS OF THE NATION'S DRUG

PROBLEM, WE ALL LOOK TO YOU TO SPEAK OUT AND OFFER LEADERSHIP SO THAT WE MIGHT BE ABLE TO OVERCOME THIS NATIONAL EMBARASSMENT.

I MUST SAY THAT I HAVE BEEN IMPRESSED WITH YOUR LEADERSHIP AND OUTSPOKENNESS ON OTHER MATTERS OF PUBLIC HEALTH AND WELFARE, SUCH AS YOUR CAMPAIGN TO STOP PEOPLE FROM SMOKING. YOU HAVE BEEN VOCAL. YOUR POSITION AND YOUR DIRECTION HAVE BEEN CLEARLY ARTICULATED. I HOPE THAT YOU WILL APPLY THE SAME SINCERITY, TENACITY AND SINGLENESS OF PURPOSE TO THE DRUG PROBLEM. THANK YOU FOR BEING WITH US TODAY, MR. SECRETARY.

STATEMENT OF

LOUIS W. SULLIVAN, M.D.

SECRETARY OF HEALTH AND HUMAN SERVICES

BEFORE THE

U.S. HOUSE OF REPRESENTATIVES

SELECT COMMITTEE ON NARCOTICS ABUSE AND CONTROL

JUNE 20, 1990

Mr. Chairman, I want to thank you for the invitation to speak to the Committee, as I did last year about this time, on drug abuse in this country and the Department's role in reducing the demand for illicit drugs in this Nation.

When I appeared last year, Mr. Chairman, you and I shared an understanding that the fight against drugs on the streets and in the schools of our Nation would require a national commitment over an extended period of time. We understood then, as we do now, that we are dealing with a chronic problem that requires constant attention, a broad range of services, and a commitment from individuals; communities; the Federal, State, and local governments; and the private sector. We acknowledged then our shared commitment to the war on drugs over the extended period, and vowed to keep up the fight. I know that we are both deeply committed to meeting this challenge. I firmly believe that we are making progress.

America has undergone and is undergoing some fundamental changes regarding its tolerance for the use and abuse of drugs. America is fighting back, and the reason why is not complicated. No caring person, especially a health professional, can stand by and watch the devastation that drug abuse has brought upon us. Drugs and alcohol are destroying families and long-held American values. They are even destroying what we had long thought was a natural bonding between mother and infant. Too much of the future of this great Nation is at risk because individuals have

become addicted to drugs or alcohol.

America's progress in the war on drugs is mirrored in surveys -- according to a recent Gallup poll better than sixty percent of the public believe we are making progress in the war on drugs. Yet, I know Mr. Chairman that this progress is not uniformly distributed. You know that from the experiences in your own district. That is why we are making significant commitments to hit the problem where the greatest need exists, especially with special populations and high risk groups. Let me outline for you Mr. Chairman current drug usage in America as we see it from our perspective.

Shortly before I testified last year we had released the results of the National Institute on Drug Abuse (NIDA) 1988 Household Survey. Respondents to the survey are interviewed in their homes by trained interviewers using self-administered answer sheets for drug use questions to maximize confidentiality and response validity. Respondents are selected randomly using a multi-stage national probability sample. The High School Senior Survey, the Drug Abuse Warning Network, and the other surveys we conduct are equally as reliable and valid. Where surveys can be expanded or otherwise improved, we are anxious to do so. For example, we are increasing the sample size in the Household Survey and adding 8th and 10th graders to the High School Senior Survey. There has been some concern that the homeless, the institutionalized and

the high school drop out populations are not adequately accounted for in the Household or Senior Survey. In response to this concern and in order to further improve our understanding of the drug abuse problem in this Nation, we will be finding ways to gather this data including using new surveys such as the Washington, D.C. Metropolitan Area Drug Study.

Last August when I testified before this Committee for the first time, I was able to report the generally positive results of the 1988 Household and High School Senior surveys. They both showed a decrease in the number of experimental, occasional, and regular drug users. It was good news for all of us, Mr. Chairman, who have been working to rid our society of one of its major problems. It is not necessary to reiterate those results here today. They have been repeated many times before Congress, in the press, and in the classrooms of this Nation. Instead, I want to mention the Drug Abuse Warning Network (DAWN) results for the fourth quarter of 1989 which I released at a recent conference of state and local government officials sponsored by the Office of National Drug Control Policy here in Washington, D.C. This survey of 431 hospitals in 21 cities across the Nation reports drug related emergency room visits. This is data, Mr. Chairman, that you and I have relied on to tell us what was happening on the streets. While we cannot suggest that this data from just one quarter constitutes a trend, the fourth quarter results showed a 22 percent reduction in the number of cocaine-related

admissions to emergency rooms. We will be looking closely at the first quarter of 1990 results to see if they are similar.

But by no means are we even close to victory. There still are over 14 million Americans who used drugs in the month before the 1988 Household survey or 7.3 percent of the population 12 or older. Of these 14 million Americans, 7.6 million were heavy users (that is, they used drugs 50 or more times during the last year) and 4 million were hard core users (that is, they used drugs 200 or more times during the last year.). Five million of the current users (use within the last 30 days) were women of child bearing age.

We cannot pull back in any way from the extraordinary effort we have been waging. But we can take some satisfaction from the fact that the data continue to show that we are moving in the right direction. This knowledge gives each of us in the Department of Health and Human Services who work on fighting drugs from the researchers, to the person who duplicates the materials we produce, a renewed spirit.

WHAT ARE WE DOING?

Earlier this year, the President released the National Drug Control Strategy II, a follow-up and refinement to Strategy I released in September of 1989. These Strategies developed by Dr.

William Bennett, Director of the Office of National Drug Control Policy, in and of themselves represent a major improvement in the coordination of the Federal response to the Nation's drug problem. The Strategies have lent order and coordination to the entire Federal response. The Department of Health and Human Services was involved in the development of both Strategies.

While every Federal agency is involved in the demand reduction efforts in some way, the Department of Health and Human Services has the primary responsibility for the demand reduction side of the National Drug Control Strategy. The Department's budget, then, reflects most of the demand side efforts of the Administration. In FY 1989 the Department estimates that it spent $935 million on its anti-drug abuse efforts including treatment, prevention and research. In FY 1990 the estimate is $1.47 billion, and we have requested $1.67 billion for FY 1991. This represents a 79 percent increase in funding targeted for drug abuse over a two year period. For treatment, HHS is requesting $924 million for FY 1991 as compared to $516 million for FY 1989 -- a 79 percent increase. For prevention efforts, the budget request for FY 1991 is almost double what was spent in FY 1989, and for research the increase is from $192 million in FY 1989 to $301 million in FY 1991 -- a 57 percent increase.

TREATMENT

Of the requested $924 million for treatment, $436 million will be funds distributed to the States through the Alcohol, Drug Abuse and Mental Health Services (ADMS) Block Grant. This is the portion of the $1.3 billion the Administration is asking for the block grant in FY 1991 which must be specifically targeted to the treatment and rehabilitation of drug users. This figure does not include monies available for alcohol or mental health services, nor does it include the 20 percent set-aside for prevention.

Before describing a few new programs we initiated in FY 1990, I want to take a moment to mention an Administration proposal which has received bipartisan support in both the House and Senate - the requirement that States develop and implement a State Drug Treatment Plan as a condition of receipt of ADMS Block Grant funds. The Administration requested legislation in conjunction with Strategy I to implement the plan as a way of holding States accountable for use and management of Federal funds. Unfortunately, the measure was never passed. With the cooperation of the National Association of State Alcohol and Drug Abuse Directors (NASADAD), we are requesting that States submit plans as part of their application for ADMS funds using existing authority. Under this authority, however, we do not have the ability to withhold a State's allotment if they fail to submit the plan which is why we are seeking legislation. Among the requirements of the proposed legislation, a State plan will have

to include the demographics of the drug abuse population in the State, how drug abuse treatment funds are meeting the needs of this population, how the State will ensure that drug treatment services will be coordinated with other health and social services, and how funds will be targeted to special populations such as pregnant and post-partum women and their infants. I urge the members of this Committee to support the measure.

In FY 1990 the Department took on several new treatment initiatives including Target Cities, Criminal Justice, and Critical Population grants. Each of these initiatives is being administered by the Alcohol, Drug Abuse and Mental Health Administration's (ADAMHA) Office for Treatment Improvement (OTI). The Target Cities initiative will provide financial and technical assistance to State selected urban areas that have been identified as having a high prevalence of drug abuse. The program supports activities designed to diminish the barriers to interagency coordination and cooperation that exist in the drug treatment system; to improve the delivery, accessibility, and success of treatment services; and to strengthen the drug treatment infrastructure. We expect to fund six to eight projects for a minimum of three years. For FY 1990, $30 million was appropriated for this activity.

We expect to fund 47 projects in 1990 under the Critical

Populations program to support improvement to existing treatment programs and treatment systems geared toward minority populations, adolescents, and residents of public housing projects. $27 million is targeted for this program in FY 1990.

We are also supporting two, three year Criminal Justice demonstration grants with a total funding of $7 million in FY 1990. The first grant will fund treatment programs for incarcerated individuals and the development of State-wide plans for improving treatment programs in criminal justice settings. The second grant is for the implementation of diversion-to-treatment programs for probationers, parolees, and misdemeanor arrestees. These two initiatives begin to focus both Federal and National attention on the need to both provide and improve treatment services to the criminal justice population. Research indicates that treatment for this population particularly can be more successful than for the population at large because of the incentive of either staying on parole or probation. If we successfully intervene in this system, we can, hopefully, stop the often repeated cycle of drug use, crime and incarceration that continues for this population.

PREVENTION

Recognizing the need for increased prevention efforts, the Administration is asking for $447 million for prevention in FY

1991 which is twice the funding level for FY 1989. This includes the 20 percent set-aside for prevention activities in the ADMS Block Grant.

The programs specifically managed by HHS include activities in the ADAMHA Office for Substance Abuse Prevention (OSAP), and the Office of Human Development Services (OHDS). The High Risk Youth program which began in 1987 continues to provide multiyear funding for community based prevention programs focusing on the multiple risk factors that lead to the probability of alcohol and other drug use among youth. The Adminstration is asking $45 million in FY 1991 for this program.

The Pregnant and Post-partum Women and their Infants program for which we are asking $38 million in FY 1991 is an important addition to the valuable demonstration grants that we have. This is a very critical population to reach, and to treat. From the projects supported by this grant, we hope to find successful strategies for preventing drug abuse among this critical population and for treating pregnant and post-partum women who have used drugs. Drug use by pregnant women does profound and potentially irreversible damage to the infant. We look forward to sharing the information we gain from these projects with the States and other providers for their implementation.

A new program this past year was the Community Partnership grants

appropriated at $50 million for FY 1990. This grant will help local communities to develop coalitions of organizations representing business, parents, schools, and industry to devise and implement a comprehensive prevention plan for the community. The Administration is asking for $101 million for this project next year.

RESEARCH

Funding for research on drug abuse increased from $192 million in FY 1989 to $255 million in FY 1990. The President requested $301 million for FY 1991 -- a 56 percent increase over two years. While these funds are used for various research efforts to learn more about drugs and drug abuse and to be able to develop prevention and treatment approaches and strategies, I want to highlight our medication development effort. ADAMHA's National Institute on Drug Abuse (NIDA) through its work at the Addiction Research Center and through research grants and contracts has been mounting a different, yet complimentary, war on drugs. While our attention has been drawn to discussion of treatment facilities and slots, NIDA supported research has been working with some success to find medications for the treatment of drug addiction. It does so with the full appreciation that such medications are not a "cure" or "magic bullet" for drug addiction, but a part of a comprehensive treatment program that includes counseling, vocational rehabilitation and other social

services.

Methadone is a medication for the treatment of opiate addiction that you are most familiar with, Mr. Chairman. Waiting for completion of trials are several potentially new treatments such as naltrexone, LAAM, and buprenorphine. Each of these medications has shown promise in the treatment of opiate addiction as well. Naltrexone is a non-addictive, long-lasting, opiate antagonist which blocks its euphoric affects, its "high." LAAM (levo-alpha-acetylmethadol) is comparable to methadone in safety and efficacy, but is longer acting. Buprenorphine, which is still in the investigative stages, both blocks the euphoric effect of an opiate and ties up the brain receptor where opiates work. Information we have so far suggests it could be used as to substitute for methadone and yet block other opiate effects at the same time. Buprenorphine also appears to decrease cocaine use in polydrug users.

Desipramine is a tricyclic anti-depressant that shows promise in the treatment of cocaine abuse in some patients. Other medications for the treatment of cocaine addiction, such as flupenthixol, are in various stages of research evaluation.

Pharmacological interventions that reduce the craving for or block the effects of various drugs are being actively pursued by government and now private sector scientists and will serve as a

very important tool in fighting the war on drugs. We support this continued research as is shown in the 56 percent increase in funding. I urge each member of this Committee to support it as well when given the opportunity to approve the President's Budget Request.

WHAT WORKS IN TREATMENT AND PREVENTION?

Congress in general and you in particular, Mr Chairman, have been very outspoken on the effectiveness of treatment and prevention activities. The Department as well has been very interested in the question and continues to do research in both the area of treatment and prevention effectiveness. Recently we submitted a report to the Senate Labor, HHS, and Education Appropriations Subcommittee on treatment effectiveness which I would like to submit for the record at this time.

As I said in my introductory remarks, drug abuse is a chronic, often relapsing disorder. For the majority of those addicted to drugs such as heroin or cocaine, a single episode of treatment will not yield a "cure." Drug users may pass through repeated cycles of drug dependence, treatment, abstinence, and relapse. But this presence of relapse in a chronic disorder does not mean treatment doesn't work. The Drug Abuse Reporting Program (DARP) and the Treatment Outcome Prospective Study (TOPS) Reports issued in 1974 and 1981 respectively verify that indeed treatment works.

But this is not something that you and I have ever questioned. The real issue is how can we make treatment work as effectively as possible. What types of modalities work best with what type of patients?

In confronting this question, we are faced with the ever changing face of drug abuse and the diversification of treatment approaches.

In conjunction with the Department of Veterans Affairs, the National Institute on Drug Abuse developed the Addiction Severity Index (ASI) to provide a problem severity profile which assesses seven areas commonly affected as a result alcohol or other drug abuse. These areas include: medical condition, employment, alcohol and drug use, legal status, family relations and psychiatric condition. This tool is being used right now by intake counselors to tailor treatment programs to the individual. Using this instrument, information is slowly being accumulated on the effects of specific types of treatment for specific subgroups. The more information we have, the better we will be able to refer an individual to a treatment program most appropriate for him or her.

The various types of modalities can be separated into two groups: pharmacological and behavioral. The breakout is somewhat artificial since these modalities whether pharmacological or

behavioral are quite often applied in conjunction with each other. This breakout does help us understand treatment from a research perspective, however. The pharmacological modalities will be evaluated through research conducted by and through NIDA. When some of the medications I discussed earlier are ready for use, recommendations on treatment will have to be prepared so that States and private providers can run effective programs.

The behavioral modalities include six approaches: psychotherapy; contingency management, wherein behavior contracts are written between a counselor and the patient; conditioning therapy, using systematic desensitization; therapeutic communities; skills development approaches; and, finally, peer support self-help groups such as Narcotics Anonymous.

We have not ascertained the precise reasons why different patient populations respond differently to varying treatments. What we have found is that there is a direct, clear relationship between the length of time spent in treatment and treatment outcomes. The longer an individual remains in treatment the more likely that person's treatment will be successful. Thus, it is important to identify and support whatever incentives an individual has to remain in treatment. Treatment motivators are as diverse as the individuals in treatment.

We also know that a continuum of services are necessary to help

an individual change the environment, or their reaction to the environment, that supported their drug abuse. It does little good to treat an individual and then return him or her to the same environment that fostered their drug abusing behaviors without aftercare to ease the transition.

We have discovered so far that for some patients, particularly individuals who have a co-existing mental health problem such as anxiety and depression, psychotherapy models work well in conjunction with other modalities. Contingency management as a form of treatment wherein an individual enters into a contract with a person requiring specific behaviors from each, works best when the individual who is being treated has something to lose, be it their professional license, probation, parole, or some other incentive.

Evaluation of treatment effectiveness can and will yield further information as we continue to explore the questions of what works. As we have done in the past, we will make this information available to States and private providers for their use in improving the effectiveness of their treatment efforts.

We also have some information on important elements of a prevention activity. We know that prevention strategies must include educational programs as well as a wide variety of other community-based activities in order to be successful. In

addition, another necessary component is the training of key health care professionals. Programs themselves must be easily accessible and provide active outreach efforts. Once early intervention has been achieved, it is critical that client contact be sustained. That is why it is vitally important that prevention activities receive a constant level of funding so as not to jeopardize the program's effectiveness. To spread out limited funds over several efforts only reduces the chance that any one of the activities will be successful.

Earlier this month, I announced research findings from community-wide drug abuse prevention programs in Kansas City and Indianapolis which show significant promise in reducing adolescent use of cigarettes, alcohol, marijuana, crack and cocaine. Program participants were only half as likely to use cocaine as those who did not participate. Early prevention works. It is the activity that will most ensure that the next generation will not face the same problem we have today.

Mr. Chairman, my statement this morning as long as it may seem is a very short, quick glimpse at what HHS is doing as part of this Administration's efforts. I have shared with you my hope for and commitment to a drug-free society. My personal commitment is strong and unfailing. I will continue to work tirelessly throughout my tenure as Secretary of HHS and thereafter as a citizen of the United States to fight this disease which has

seriously affected the social and moral fiber of this country.

Mr. Chairman, thank you for the opportunity to testify here this morning. I would be pleased to answer any questions you might have but I would ask that Dr. Frederick Goodwin, Administrator of the Alcohol, Drug Abuse, and Mental Health Administration, Dr. Charles Schuster, Director of the National Institute on Drug Abuse, Dr. Beny Primm, Director of the Office for Treatment Improvement and Dr. Elaine Johnson, Director of the Office for Substance Abuse Prevention, join me at the table so we can give the most comprehensive answers possible to your questions.

HHS NEWS

MIDWESTERN DRUG ABUSE PREVENTION RESEARCH PROJECT--EVALUATION FINDINGS

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

For Immediate Release
June 1, 1990

Contact: Mona W. Brown
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The Department of Health and Human Services released research findings from community-wide drug abuse prevention programs in Kansas City and Indianapolis which show significant promise in reducing adolescents' use of cigarettes, alcohol, marijuana, and--for the first time--crack and cocaine. Reductions of at least 25 percent were seen in cigarette smoking, 20 percent in drinking and 30 percent in marijuana use.

"This new research strengthens the point that drug abuse prevention is our front line of offense in reducing this nation's demand for illicit drugs", Secretary Sullivan said.

Preliminary findings on cocaine use also show that non-program participants were more than twice as likely to have used cocaine in the past month as program participants. "We are encouraged with these preliminary findings since cocaine use has wreaked havoc on our public health--destroying individuals, families, communities," said Dr. James O. Mason, assistant secretary for health.

"After four years of evaluation, the findings clearly show that students who were in the comprehensive prevention program were significantly less likely to be drinking alcohol and smoking cigarettes and marijuana than their peers not in the program," explained Dr. Frederick K. Goodwin, administrator of the Alcohol, Drug Abuse, and Mental Health Administration.

(more)

Evaluation of the Midwestern Drug Abuse Prevention Research Project was funded by the National Institute on Drug Abuse and conducted by researchers from the University of Southern California.

Dr. Charles R. Schuster, director of NIDA, said, "This program is unique because it utilizes all components in the community--schools, parents, the media and community groups--which contribute to changing the social norms for drug use and providing a healthy drug-free environment for all people."

The researchers found that changing social norms is more effective than just changing individual resistance skills or providing information on the consequences of drug use.

The program was implemented through support from private foundation grants beginning in 1984 in 50 middle and junior high schools in Kansas City, and in 1987 in 57 schools in Marion County (Indianapolis) Indiana.

Major findings after five years of evaluating the program in Kansas City include:

* 36 percent of students who participated in the program drank alcohol in the last month, while 50.1 percent of adolescents not in the program admitted the same behavior.

* 24.1 percent of the students taking part in the study smoked cigarettes in the last month while 32 percent of the teens not receiving the program's prevention messages were smoking.

* 14.2 percent of the program students had tried marijuana in the last month compared with 20.2 percent of the non-participating adolescents.

(more)

Preliminary analyses of eight of the study schools (in which students are tracked individually over time) have shown that 1.6 percent of the program students used cocaine in the last month, including crack, while 3.7 percent of the non-program adolescents used cocaine or crack in the last month. Further analyses also indicate that while 17.8 percent of students in the drug prevention program tried amphetamines one or more times in their lives, 22.2 percent of their non-program peers admitted the same behavior.

"This study clearly demonstrates that a comprehensive prevention program can work in reducing not only the use of cigarettes and alcohol, but also the use of illicit drugs as well," said Dr. Mary Ann Pentz, principal investigator of the study.

The Midwestern Prevention Research Project was designed on the basis of recent research which indicates that a comprehensive prevention program may be more successful than a program which relies on the schools alone to teach students to resist drugs. "School-based programs may not be enough to change students' drug use over the long term, mainly because there are so many competing pressures for students to use drugs once they leave the school setting," Dr. Pentz said.

The five components of the comprehensive drug abuse prevention program include:

SCHOOLS: Each year, students entering middle or junior high school for the first time receive instruction on how to recognize and respond to social pressures and resist involvement with drugs and alcohol.

(more)

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PARENTS: Through homework assignments, parents are encouraged to establish family rules concerning substance use, discuss the consequences of use, and share their reasons for not wanting their child to become involved with alcohol or other drugs. Parents are also trained to implement prevention activities in and around all schools and to enhance their communication and rule-setting skills with their children.

MASS MEDIA: Press materials are developed and distributed to increase general community awareness of and interest in participation in the program. Video contests, commercials, talk shows, and news shows are also used to illustrate prevention skills and reinforce participants in the program.

COMMUNITY: Community leaders identify additional areas of need for prevention programming and focus their energy on encouraging schools, law enforcement, and other agencies to support healthy and rewarding activities for young people.

POLICY: As attitudes change, policies are made to support these changes; for example, implementing laws prohibiting smoking in public places, and sales of alcohol to minors.

ADAMHA's Office for Substance Abuse Prevention is conducting services demonstrations which flow from these findings and further extend this work into comprehensive community prevention projects across the nation. In addition, the Office for Substance Abuse Prevention and the National Institute on Alcohol Abuse and Alcoholism are coordinating a joint research effort which will further enhance these community prevention efforts.

Dr. Schuster said, "Success of the drug prevention programs in Kansas City, Indianapolis, and other areas of the country often reflect leadership by individuals or community coalitions where local organizations provide impetus for implementing large scale programs that work. Students, parents and community leaders must all actively contribute to a drug-free environment."

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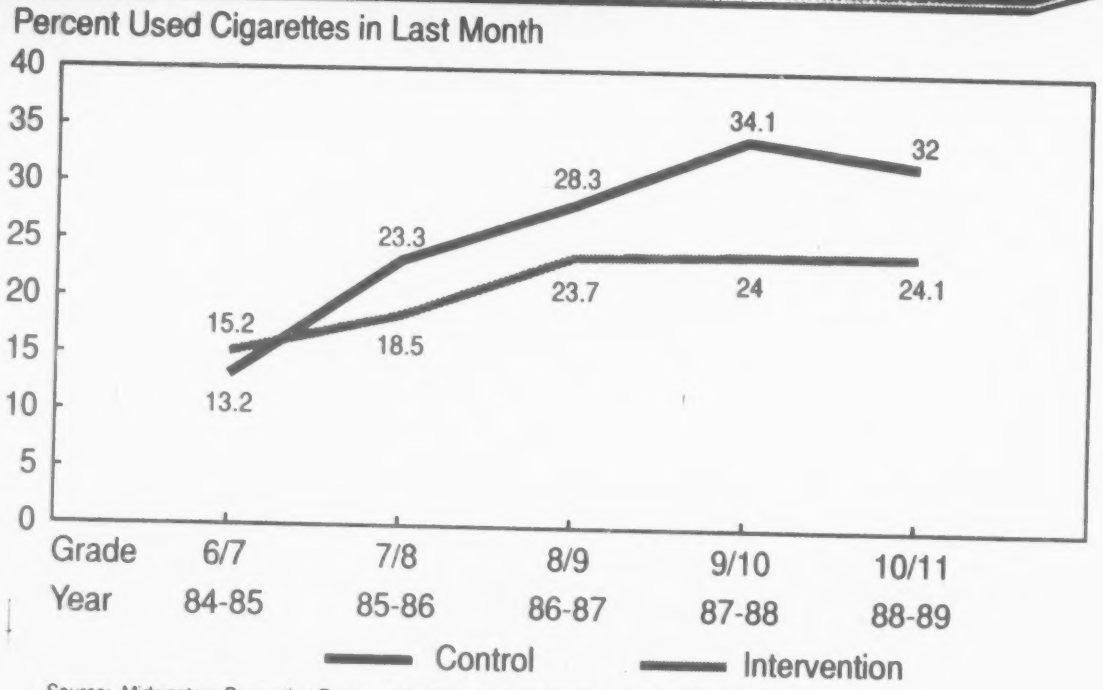
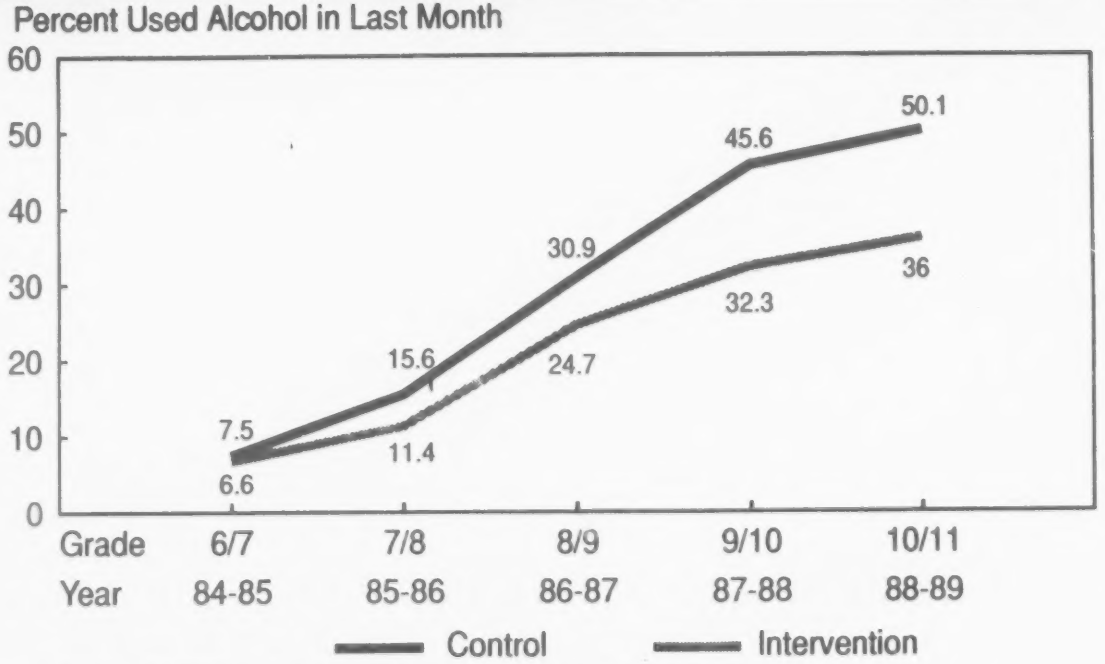
Cigarette Use



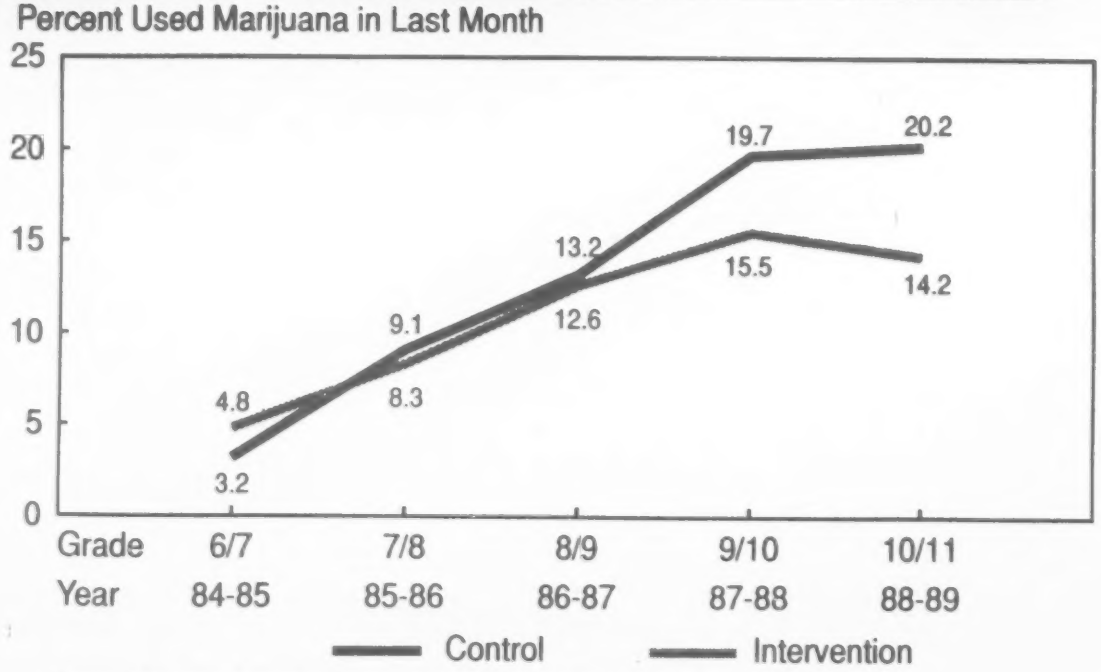
Source: Midwestern Prevention Research Project, National Institute on Drug Abuse

Alcohol Use



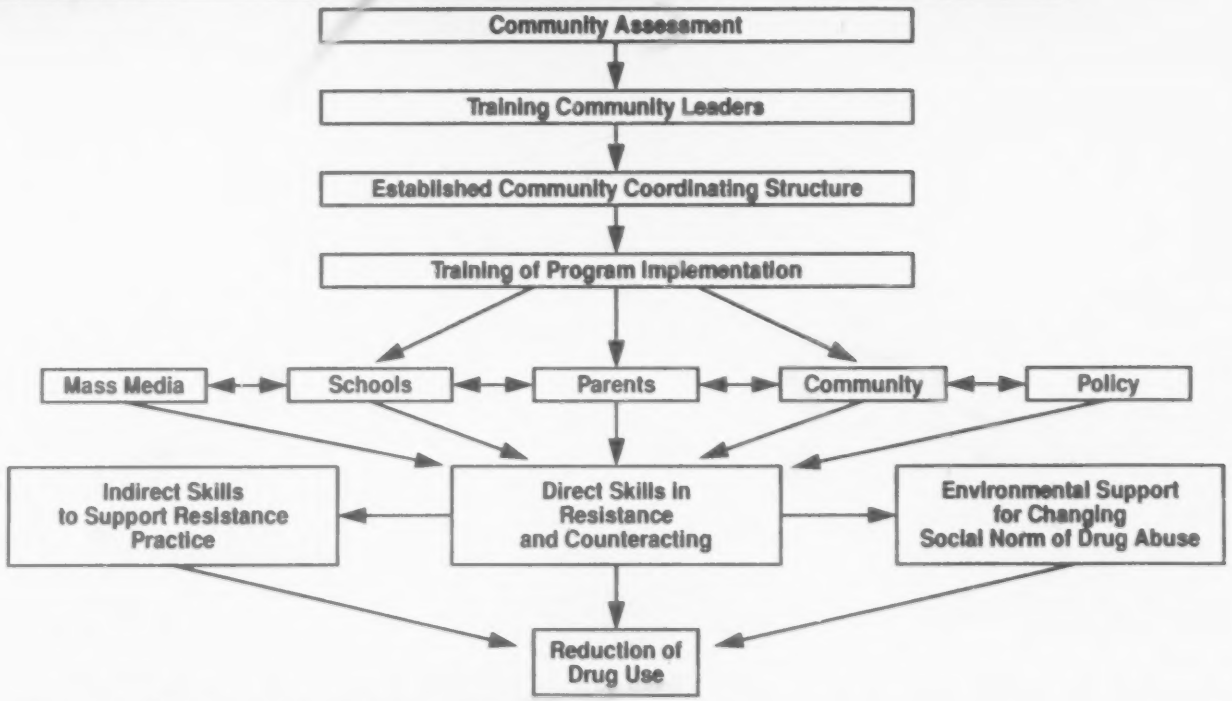
Source: Midwestern Prevention Research Project, National Institute on Drug Abuse

Marijuana Use



Source: Midwestern Prevention Research Project, National Institute on Drug Abuse

Intervention Model



Source: Midwestern Prevention Research Project, National Institute on Drug Abuse